NPI Established 1970
The Neuropsychiatric Institute

RELEASE/AUTHORIZATION

Authorization for SPECIAL LETTER/PAPERWORK to be sent via:

☐ Electronic via Patient Portal ☐ Fax number listed below
☐ Call requester when ready for pick-up with amount of copying fee

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PATIENT INFORMATION:

Patient Name (first, middle, last) (please print): ______________________________

Date of Birth: ____________________ Phone: (_______)____________________

Street Address: ____

City:______________________ State:__________ Zip Code:________________

SPECIFIC INFORMATION TO BE RELEASED: ______________________________

____

TO THE FOLLOWING INDIVIDUAL:

Person/Organization: ____

Relationship to Patient (if any): ______________________________________

Street Address: ____

City:__________________________ State:__________ Zip Code:____________

Phone: (_____)____________________ Fax: *(preferred)* (_____)____________________

*I understand that I have the right to refuse this authorization and that the facility named above is released from all legal liability that may arise from the release of the information requested.
** I specifically authorize the release of DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION to the person or entity indicated herein.

Patient/Legal Representative: ______________________________ Date: ____________
(Signature must be handwritten)

If other than Patient, please print Name: ______________________________

Relationship to Patient: ______________________________________

Witnessed by: ______________________________________ Date: ____________

This form can be scanned and emailed to our secure Patient Portal. *Please call the office to request an invitation*. More information can be found at our website: www.neuropsychiatric.net

Rev.07/2023