

Aspiring Minds
Neuropsychological Assessment & Psychotherapy Clinic

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Authorization for Use or Disclosure of Health Information

Patient Information

Name: _____
Date of Birth: _____
Address: _____
Phone: _____

I hereby authorize **Ludmila Zaytsev, Ph.D.** to release/request medical records

release to:

request from:

Name or Professional/Organization: _____
Address: _____
Telephone: _____

Information to release/request:

Reason for this request:

- Continuing care
- Insurance
- Legal

- Personal Use
- Other _____

Patient Signature

Date

Parent or Legal Representative

Date

This authorization is valid for 180 days and can be revoked in writing at any time.