PRINCETON Neuropsychology at RSM | Sports Concussion Center of New Jersey

11/2023

CONSENT FOR DISCLOSURE OF PATIENT RECORDS OR COMMUNICATION

(Only complete this form if you would like us to share your information with another person, another doctor, or your insurance company)

I hereby authorize **Princeton Neuropsychology at RSM/SCCNJ/** to disclose information and/or receive information to the extent or nature indicated to/from Recipient Name/Address/Contact Info: _____ _____ for the purpose of **case consultation, record release, and/or billing**. The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose and may include the following items (unless crossed out by me):

- Drug and/or alcohol abuse information
- Information regarding Immunodeficiency virus (HIV) including laboratory test results
- Diagnosis of AIDS or ARC, if applicable
- History and physical examinations
- Psychological & neuropsychological test results
- Raw data from psychological and neuropsychological tests
- Clinical notes, including correspondence and billing/insurance information
- Psychological and neuropsychological reports
- Other: _____

Regarding: **(Patient Name)**_____ whose date of birth is _____ and whose social security number is _____.

I understand that in New Jersey the communications between patients and psychologists are privileged and confidential and, in most instances, may only be released with my written consent. I also understand that I may revoke this consent at any time except to the extent action has been taken in reliance thereon. This consent is effective immediately and will expire after 365 days from the date of signature. However, I also understand that I may revoke my consent before 365 days elapses by writing to you and withdrawing my consent. This consent is for the above stated purposes only and specifically does not authorize the release of documents or information therein to any other party except as required in the filing of court documents in connection with the aforesaid purpose. I understand that treatment, payment, enrollment, or eligibility for benefits in an insurance plan that is not ERISA exempt cannot be a condition of authorization of psychotherapy notes (not progress notes as defined by HIPAA, federal law). I understand that once information is released, there is potential for that information to be redisclosed and no longer protected by HIPAA. A photocopy of this consent form is as good as the original. I hereby release Princeton Neuropsychology at RSM/SCCNJ and its employees, personnel, officers, directors, and professional health care providers from any and all legal responsibility or liability resulting from the release of the above information to the extent indicated and authorized herein.

Patient (13 years or older) Signature:_____

Parent/Legal Guardian (if Patient is under 18 years of age) Signature:_____

Other Parent/Legal Guardian Signature, *if required*:_____

Today's Date_____

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