Release of Medical Records (Request Authorization)
to assist with Neuropsychological Evaluation

Name:_____ DOB: _____ Today's Date _____

Address: _____
Street City, State Zip Code

I give my permission for _____
to release the records noted below to:

Dr. Lori E. Azzara
Commonwealth Neurobehavioral Associates
(Mailing Address) 20 Roche Brothers Way, N. Easton, MA 02356
Voice: 508-930-3553 ***Fax: 877-509-2367***

To assist in the neuropsychological/psychological assessment process including to

- ☐ Assist with treatment planning
- ☐ Document a need for services
- ☐ Support an application for _____
- ☐ Other (be specific): _____

Records requested include:

- ☐ Previous psychological/neuropsychological assessment results
- ☐ Pertinent medical records
- ☐ Nursing Home records
- ☐ Other (specify) _____

I hereby freely, voluntarily and without coercion, authorize the release of information noted above to Dr. Lori Azzara, Commonwealth Neurobehavioral Associates. This consent will last one year from the date signed. I understand that I may revoke my consent at any time.

_____ _____ _____
Signature Printed name Date

_____ _____ _____
Signature of parent/guardian Printed name Date

☐ Copy for client or parent/guardian ☐ Copy for records