

**Main Line Neuropsychology, PLLC**  
**Jennifer Badgley, PhD**  
**Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301**  
**Mailing Address: 43 Paoli Plaza #1448, Paoli, PA 19301**  
**Phone: 610-500-4700 Fax: 484-585-1673**

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***Adult Authorization for Release of Health Information***

I, \_\_\_\_\_, \_\_\_\_\_,  
(print full name) (date of birth)

hereby authorize the release of my health information

From/To:

Name: \_\_\_ Main Line Neuropsychology, PLLC/ Jennifer Badgley, PhD \_\_\_\_\_  
Address: \_\_\_ 30 S. Valley Road, Suite 207 \_\_\_  
City, State, Zip: \_\_\_ Paoli, PA 19301 \_\_\_\_\_  
Phone: \_\_\_ 610-500-4700 \_\_\_ Fax: \_\_\_ 484-585-1673 \_\_\_\_\_

To/From:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Purpose of disclosure:

continuity of care     insurance/reimbursement     other (specify: \_\_\_\_\_)

Information requested:

all     specific items (specify: \_\_\_\_\_)

I give my permission for the information listed above to be released to the above named recipient. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 180 days after the date signed. The recipient should not redisclose my medical record to another party without further written consent.

I will not hold Main Line Neuropsychology, PLLC or Jennifer Badgley, PhD liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking Main Line Neuropsychology, PLLC or Jennifer Badgley, PhD for clarification of the information therein.

I understand and acknowledge that this authorization permits the release of information in the record that may include alcohol/drug abuse, mental health, or HIV/AIDS information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name: \_\_\_\_\_