

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

Child Authorization for Release of Health Information

I, _____, hereby authorize the release of health
(print full name)

information of my child, _____,
(print full name) (date of birth)

From/To:

Name: ___ Main Line Neuropsychology, PLLC/ Jennifer Badgley, PhD _____
Address: ___ 30 S. Valley Road _____
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 child's 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: _____ Relationship to child: _____