Main Line Neuropsychology, PLLC
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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: _____