Main Line Neuropsychology, PLLC
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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: _______________