BRAiN SERVICES
Brisman Associates in Neuropsychology, PLLC

Michelle A. Brisman, Ph.D.
231 Farmington Avenue
Farmington, CT 06032
860-707-2775 TEL | 860-540-1114 FAX
brainservicesinfo@gmail.com
brainservicesinfo.com

Release of Protected Health Information
Authorization Form

Patient Name: _____ DOB: ____/____/____

Patient Address: (Street) _____

(Town/City) _____ (State) _____ (Zip Code) _____

Patient: Home Phone _____ Cell Phone _____ Email _____

I authorize Michelle A. Brisman, Ph.D., and/or her administrative and clinical staff to:

❑ release information from the health record to assist with my evaluation and/or treatment to:
❑ receive information from the health record to assist with my evaluation and/or treatment from:

Name/Organization: _____

Phone Number: _____ Fax Number: _____

(Street) _____

(Town/City) _____ (State) _____ (Zip Code) _____

Requested information: ❑ Office notes ❑ History/physical ❑ Discharge summary
❑ EEG report ❑ Laboratory findings ❑ Radiology: Films/report
Other: _____

Approximate date(s): _____

This authorization shall remain in effect until: _____
If no expiration date is listed above, I understand that the expiration date is one-year from my signature below.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient/Legal Representative* Date

**If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.*