SHORELINE PEDIATRIC NEUROPSYCHOLOGICAL SERVICES, L.L.C.
ASSESSMENT AND CONSULTATION SERVICES

SHELLEY F. PELLETIER, PH.D., NCSP, ABPP
LICENSED PSYCHOLOGIST
BOARD CERTIFIED IN SCHOOL PSYCHOLOGY
BOARD CERTIFIED IN CLINICAL NEUROPSYCHOLOGY
BOARD CERTIFIED SUBSPECIALIST IN PEDIATRIC NEUROPSYCHOLOGY

Request for the Release of Records

Client Name: _____ Date of Birth: _____

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Connecticut State Law,

□ I, (print name) _____, hereby authorize Dr. Shelley Pelletier to OBTAIN the following protected health information (PHI) from _____ (name of record holder).

□ I, (print name) _____, hereby authorize Dr. Shelley Pelletier to DISCLOSE the following protected health information (PHI) to _____.

Address: _____

Phone: _____

Please check appropriate box or boxes:

_____ Dates of Admission or discharge.

_____ Diagnosis

_____ Pertinent medical, educational, psychological, psychiatric, substance abuse, and /or social service information relevant to diagnosis and/or treatment.

_____ Other information (please be specific _____

This release or disclosure is for the following reasons: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.) _____

This authorization shall remain in effect until _____, or no longer than six months from today.

I acknowledge that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address listed below. However, my revocation will not be effective to the extent that you 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 Date
Or_____
Signature of Parent, Guardian, or Personal Representative
(specify)

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MAILING ADDRESS
P.O. BOX 303
OLD SAYBROOK, CT 06475

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954 MIDDLESEX TURNPIKE, STE A2
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