



**THE  
NEUROBEHAVIORAL  
CLINIC & Counseling  
Center**

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**RELEASE OF INFORMATION**

I, \_\_\_\_\_, hereby authorize THE NEUROBEHAVIORAL CLINIC & COUNSELING CENTER, its agents or employees to disclose my neuropsychological records to:

\_\_\_\_\_  
\_\_\_\_\_

or to receive information from:

\_\_\_\_\_  
\_\_\_\_\_

for the purpose of: \_\_\_\_\_

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate one year from the date it was signed.

I have carefully read and I understand the foregoing. I consent to the release of the above specified information or records. I further release THE NEUROBEHAVIORAL CLINIC & COUNSELING CENTER, and its associates from any liability, if any, from the release or exchange of this information to such designated persons or agencies.

\_\_\_\_\_  
**SIGNATURE OF PATIENT**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**SIGNATURE OF AUTHORIZED AND/OR RESPONSIBLE INDIVIDUAL/GUARDIAN**

\_\_\_\_\_  
**DATE**