WINS*i*

WESTERN INSTITUTE FOR NEURODEVELOPMENTAL STUDIES AND INTERVENTIONS
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AUTHORIZATION TO RELEASE AND SHARE CONFIDENTIAL INFORMATION

Patient's Name: _____ _____ _____ _____/_____/_____
First Name *MI* *Last Name* *Date of Birth*

Kytja Voeller, M.D., Jill Gitten Aloia, Ph.D., ABPP-CN, and the staff of WINSi are hereby authorized to obtain information from, and share information with, the following professional or agency:

_____
Name

_____
Address

_____ _____ _____
City *State* *Zip Code*

_____ _____
Phone Number *Email*

This information may include: (*Check all that apply.)*

- ☐ **All Health and Academic Records *(including all items listed below)***
- ☐ Psychiatric History, including Diagnosis and Treatment
- ☐ Psychological/Neuropsychological Testing/Consultations
- ☐ Psychological Education Evaluations
- ☐ Inpatient Hospital Records
- ☐ Diagnostic Studies
- ☐ Academic Records and School Behavioral Reports
- ☐ Special Education Records
- ☐ Speech/Language, Occupational Therapy Evaluations

PLEASE READ BEFORE SIGNING:
I understand that signing this authorization is voluntary, and that the Western Institute of Neurodevelopmental Studies and Interventions (WINSi) will provide treatment regardless of if I sign this authorization.

I understand that if I authorize WINSi to disclose information, the recipient of the information might disclose it to others, and that any information disclosed by WINSi may no longer be protected by the federal rule on privacy of medical records.

I understand that the material to be released may include information regarding Drug and Alcohol Abuse, Neurological or Psychiatric Conditions, and/or HIV/Auto Immune Deficiency Syndrome. If the information to be released pertains to the diagnosis and treatment of alcoholism or drug abuse, I understand that the confidentiality of the information is protected by Federal Law 42, C.F.R., Part 2. Federal regulations prohibit the person receiving this information from making further disclosure of the information without specific written consent of the person to whom it pertains.

This authorization to release/request information will expire one year from the date of signature and may be revoked at any time by giving written notice to WINSi. I understand that the cancellation will not be effective until it is received by WINSi, and it will not apply to information that has already been released in response to this authorization. I also understand that a cancellation will not affect the healthcare, the payment of healthcare, and healthcare benefits of the above-named individual.

_____ _____/_____/_____
Signature of Patient or Legal Guardian *Date*

_____ _____
Printed Name of Patient or Legal Guardian *Relationship to Patient*