New Peaks
NEUROPSYCHOLOGY
777 29th Street, Suite 200, Boulder, CO 80303
Office: 303-200-4780 • Fax: 720-647-3011

Kristin B. Powell, Ph.D., ABPP-CN
Jill Gitten Aloia, Ph.D., ABPP-CN
Zachary W. Sussman, Ph.D.
Emily C. Maxwell, Ph.D.

AUTHORIZATION TO REQUEST OR RELEASE CONFIDENTIAL INFORMATION

Client's Name: _____

Date of Birth: _____

I hereby authorize New Peaks Neuropsychology to: ☐ request information from / ☐ release information to / ☐ exchange information with the following individual, provider, or institution (please check one to specify direction of exchange).

_____
Individual, Provider or Institution

_____
Address

_____
Telephone Fax

Specific Information Requested: _____

_____
[Neuropsychological evaluation results, medical records, treatment/progress notes, verbal consultation between providers, psychological testing, educational testing, educational plans, staffing reports, IQ tests and scores, school transcripts, college entrance exam scores, complete school records including special education records.]

The purpose for the release of these records is evaluation and treatment planning. This authorization extends to the release of any drug and alcohol related information in the record. This authorization may be revoked by notifying your provider in writing. A photocopy of facsimile transition of this release shall be accepted as the original. Unless otherwise indicated here (expires_____), this authorization expires 24 months from the date signed. Any information released by this office to another individual or entity shall not be forwarded without written and further consent by the patient or guardian.

I understand that I have the right to receive a copy of this authorization upon my request.

Signature of Client or
Legal Representative:_____ Date: _____

If the child is over the age of 14, please obtain their signature as well.

Signature of Teenager:_____ Date: _____

Signature of Witness:_____ Date: _____