BRAIN AND BODY INTEGRATION

1115 ELKTON DRIVE, SUITE 301, COLORADO SPRINGS, CO 80907

Request for Release of Evaluation Reports

Patient's Full Name:_______________________________ Former Name(s):_____________________
Date of Birth_______________________ Phone:____
Address:____

Please note: Request are subject to payment of copying /mailing fees after first copy. Payment is due at time of pick up. You may pick up your evaluation report after 1pm the following day.

Person(s) to pick up this evaluation report:____

- Will pick up
- Please mail
- Other____
  (identification is required when picking up evaluation reports)

I hereby authorize Brain and Body Integration, its affiliates, staff, employees and their representatives to release my protected mental health information in the manner listed below and to the following:

Mail to:____
Address:____
City, State, Zip:____

Type of Evaluation Report requested:

- Adaptive Functioning
- Autism Spectrum
- IQ/Learning Disorder
- Neuropsychological
- Psychological

Purpose for release of evaluation report:

- At my request
- Continuity of care
- Other:_________________________

Signature: By signing below I acknowledge I have read and agree with all of the above.

Signature:_____________________________________ Date:____________________

Print Name:__________________________________ Relationship to patient:__________________