MATT F. BUTRYN, PH.D., LLC
ATHENS NEUROPSYCHOLOGY AND COUNSELING
AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION (PHI)

_____	_____	_____
Name of Patient/Client	Date of Birth	Additional Identifying Information

I HEREBY AUTHORIZE:

Matt F. Butryn, Ph.D., LLC
1 Huntington Road, Suite 802
Athens, GA 30606
Phone: 706-548-0018
Fax:706-548-2389

TO RELEASE TO:

_____
(Name of Person Receiving Records)

_____
(Relationship to Patient/Client,e.g.,Parent, Spouse, Legal Guardian, etc.)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
(Telephone or Fax #)

By signing this release of information, I give my consent for Dr. Butryn and his agent(s) to release:

1. Report of Evaluation

Please choose how you would like the Report of Evaluation to be released:

- ☐ Standard USPS Mail (will be sent to address given above)
- ☐ Email (provide email address here): _____
- ☐ Fax (Please provide fax # here): _____
- ☐ I will pick up in person (Please schedule a time to pick the report up with our office manager)

I understand and agree that:

1. I may revoke this authorization at any time in writing and present my written revocation to this office.
2. The revocation will not apply to information that has already been released in response to this authorization.
3. I may refuse to sign this authorization.
4. Disclosure of health information is voluntary.
5. I need not sign this authorization to ensure treatment nor will it affect my payment status.
6. Any disclosure of information carries with it the potential for an unauthorized redisclosure.
7. I may inspect or have a copy of the information described on this form if I ask for it, unless otherwise prohibited by law.
8. I can get a copy of this form after I sign it if I request that.

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released without proper consent. I understand this authorization includes the release of a Report of Evaluation performed at this office.

If I have any questions about the disclosure of my protected health information, I can contact this practice's Privacy Officer/Office Manager. I have read the above and authorize the disclosure of the protected health information as stated. If I fail to specify an expiration date, this authorization will expire in one (1) year from the date of the signature.

This authorization expires on: _____

By signing, I understand that I am authorizing Matt F. Butryn, Ph.D., LLC/Athens Neuropsychology to release a copy of the Report of Evaluation as described above. I hereby release Dr. Butryn and his affiliates, directors, employees, staff members, and agents from any and all claims, liability, suits, or costs related to the use of images or disclosure of the information and materials described herein.

_____ _____
(Signature of Client or Legal Representative) (Date)
Authority to act on behalf of patient/client (**attach appropriate documentation**): _____