AUTHORIZATION TO RELEASE RECORDS

NJ MEMORY CENTER

80 Pompton Ave., Suite 106
Verona, NJ 07044
Phone: 201-577-8286
Fax: 201-479-0299

I, ________________________________ authorize the verbal release of personal health information relevant to my care to the following individuals and I understand that this consent will remain in effect until revoked in writing:

Name:______________________________________ Relationship: ____________________________

Name: ______________________________________ Relationship: ____________________________

I, ____________________________________ authorize the NJ Memory Center to release my neuropsychological report to the following recipients:

Name: ____

Agency/Office: ____

Address: ____

City: ______________________________ State: _____ Zip: ______________

Phone: ____________________________________ Fax: ____________________________________

Name: ____

Agency/Office: ____

Address: ____

City: ______________________________ State: _____ Zip: ______________

Phone: ____________________________________ Fax: ____________________________________

Name: ____

Agency/Office: ____

Address: ____

City: ______________________________ State: _____ Zip: ______________

Phone: ____________________________________ Fax: ____________________________________

______________________________ ______________________________ ______________________________
Signature Print Name Date

______________________________ ______________________________ ______________________________
NJMC Representative Print Name Date