AUTHORIZATION FOR RELEASE OF MEDICAL AND MENTAL HEALTH RECORDS

NEUROPSYCHOLOGY ASSOCIATES OF FAIRFAX
3020 HAMAKER COURT SUITE 103
FAIRFAX, VA 22031

Phone: 703-876-0966
Fax: 703-876-1628

I,_____authorize
(Print Name)

the following person/agency:

Name: Dr. _____

Agency/Office: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

to release all health related records to Neuropsychology Associates of Fairfax, 3020 Hamaker Court Suite 103, Fairfax, Va 22031. Please fax records to (703) 876-1628:

_____ _____
Signature Print Name

_____
Date

_____ _____
NAF Representative Print Name

_____
Date