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: _____

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_____