NeuroSync TMS THERAPY

4007 Bridgeport Way W, Ste B
University Place. WA 98466
Website: www.tmsandgp.com
Email: info@tmsandgp.com
Fax: 984-302-3632
Phone: 253-234-4199

CLIENT CONSENT TO RELEASE INFORMATION

Client Name:_____Date of Birth: _____
Other Alias:_____SSN:_____/

I hereby authorize the below **Health Care or Pharmacy Providers** to use or disclose, in verbal and/or written form, the specific information requested below, to NeuroSync TMS Therapy for the purpose of receiving TMS therapy and to obtain prior authorization for TMS treatment services.

(Doctor Name)_____Tele: _____Fax:_____

(Doctor Name)_____Tele:_____Fax:_____

(Pharmacy)_____Tele:_____Fax:_____

(Pharmacy)_____Tele:_____Fax:_____

(Hospital)_____Tele:_____Fax:_____

(Therapist)_____Tele:_____Fax:_____

(Other)_____Tele:_____Fax:_____

One-Way Release: _____ Two-Way Release: _____

We have checked the minimum records needed to obtain a prior authorization for TMS therapy. Please check any other applicable mental health records you authorize us to request.

- ■ Treatment Summary
- ☐ Psychological Testing
- ☐ Psychological Evaluation
- ■ Psychiatric History
- ☐ Substance Use/Abuse History
- ☐ School Functioning/Educational
- ☐ School Testing/Evaluations
- ☐ Medical Information History
- ■ Current / Previous Medications
- ☐ Hospital Admit Summary
- ☐ Hospital Discharge Summary
- ☐ Other:

The information is being requested for the following purpose(s): Transcranial Magnetic Stimulation (TMS therapy)

This authorization shall remain in effect for 90 days from the date of the request.

Date of Request: ____/____/_____

Continued on the reverse

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This authorization shall remain in effect 90-days from the date signed below.

I understand that:

- ♦ I may inspect or copy the protected health information to be used or disclosed.
- ♦ I understand that I may revoke this authorization any time before the expiration date (except to the extent that actions have been taken in reliance on it) by submitting a written revocation letter to NeuroSync TMS Therapy.
- ♦ Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- ♦ I may refuse to sign this authorization
- ♦ I hereby release NeuroSync TMS Therapy from any and all legal responsibility or liability or for any consequences of either: 1) having non- stipulated information maintained in confidence or privacy; or 2) disclosing stipulated information.

Client Signature: _____ Date: _____
(Age 18 and over)

Parent/Guardian Signature:_____ Date: _____

Witness Name:_____ Date:_____
The witness can attest to the identity of the person(s) signing above, per secure, written, identifying information.

NOTICE TO RECEIVING AGENCY: The patient's record is privileged information, which is protected by various State and Federal laws. Such information may not be disclosed to other persons or entities, including those within the organization wherein the patient is employed, without a separate written authorization from the patient.

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