

Johnson Neuropsychology, PLLC

Request/Authorization for Release of Information

Patient:

Address:

Phone:

Date of Birth:

I give my permission to Johnson Neuropsychology, PLLC to exchange information relating to my/my child's medical, educational, and mental health between staff and:

1. Name: **FAA**

Address: 6500 S MacArthur Blvd CAMI Bldg 13, Room 308, AAM-300
Oklahoma City, OK 73169

Phone:

Fax: 405-954-4300

2. Name:

Address:

Phone:

Fax:

3. Name:

Address:

Phone:

Fax:

Patient Name (Printed): _____

Patient Signature (or parent/guardian if patient is a minor): _____

Date: _____