

# Texas Neurology, PA Authorization to Obtain Medical Information

I, \_\_\_\_\_, hereby authorize Texas Neurology, PA to obtain the following information by \_\_\_\_\_ mail, \_\_\_\_\_ Fax, \_\_\_\_\_ orally, \_\_\_\_\_ email from the patient:

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone or Fax: \_\_\_\_\_

From the health records of: \_\_\_\_\_  
(Name of person whose record will be disclosed)

For the purpose of: \_\_\_\_\_

My authorization extends only to those data elements/documents marked below:

- |                                                                                                              |                                                             |
|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> All records                                                                         | <input type="checkbox"/> Progress notes                     |
| <input type="checkbox"/> Statements of charges or payments                                                   | <input type="checkbox"/> Discharge summary                  |
| <input type="checkbox"/> Records of all visits                                                               | <input type="checkbox"/> Consultation reports               |
| <input type="checkbox"/> AIDS or HIV information                                                             | <input type="checkbox"/> Hepatitis information              |
| <input type="checkbox"/> History and physical information                                                    | <input type="checkbox"/> Photographs, videos, images        |
| <input type="checkbox"/> Record of visit for specific date(s)<br>dates limited to: _____                     | <input type="checkbox"/> Distribution of medication samples |
| <input type="checkbox"/> Copies of records or reports provided to the above named (i.e. hospital, lab, etc.) |                                                             |
| <input type="checkbox"/> Mental health and/or alcohol and drug abuse treatment                               |                                                             |
| <input type="checkbox"/> Other (must be specific) _____                                                      |                                                             |

This authorization is given freely with the understanding that:

- 1.) Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
- 2.) A photocopy or fax of this authorization is as valid as this original.

- 3.) I may revoke this authorization at any time, except where information has already been released. To revoke my authorization, I must submit a Revocation of Authorization to Release Medical Information Form to the clinic. The clinic will act upon my revocation within two working days of receipt. This authorization is valid for a one year period from the date it is signed, or sooner if noted below.
- 4.) Texas Neurology, PA, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- 5.) Information used or disclosed pursuant to the authorizations may be subject to disclosure by the recipient and may no longer be protected by this rule.
- 6.) Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.
- 7.) The patient will be provided with a copy of this authorization.

\_\_\_\_\_  
 Patients Printed Name

\_\_\_\_\_  
 Patient's Date of Birth

\_\_\_\_\_  
 Signature (Patient/ Legal Representative)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient

\_\_\_\_\_  
 Witness

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Expiration Date of Authorization to  
 Release Medical Information  
 (60 days of Signature Date)

**Please Mail To:**  
**Texas Neurology, P.A.**  
**6301 Gaston Ave. Suite 100 West**  
**Attn: Medical Records**  
**Dallas, Texas 75214**

**Or**

**Fax To:**  
**214 821 4017**