

Texas Neurology, PA Authorization to Release Medical Information

I, _____, hereby authorize Texas Neurology, PA to disclose the following information by _____ mail, _____ Fax, _____ orally, _____ email to:

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)
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