# TEXAS NEUROLOGY

## Authorization to Obtain or Release Medical Information

Name: _____ Date of birth: _____
*First MI Last*

I _____, hereby authorize Texas Neurology to obtain or release my health records for the purpose of medical treatment and/or evaluation information by: ❑ Mail ❑ Fax ❑ Orally to:

Referring/PCP name: _____ Phone: (_____) _____ - _____

Address: _____ Fax: (_____) _____ - _____

City: _____ State: _____ Zip: _____

My authorization extends to: ❑ All records ❑ Other (Please specify): _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or electronic format, are confidential and cannot be disclosed without prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this is valid as the original.
3. I may revoke this authorization at anytime, except where information is already been released. To revoke my authorization, I must submit a Revocation of Authorization of Medical Information Form to the office.
4. Texas Neurology, 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 authorization may be subject to discloser 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.

x _____ x _____
*Patient's Printed Name* *Date of Birth*

x _____ x _____
*Patient/Legal Representative Signature* *Date*

x _____ x _____
*Relationship to Patient* *Witness*

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*Revised 6/1/2013*