Authorization for Release of Medical Information

I, _____authorize
(Patient's Name – PLEASE PRINT CLEARLY)

_____whose address is
(Releasing Physician/Facility)

_____
(Street, City, State, Zip Code)

to release information from the medical record of:

_____ _____ _____
Patient Name Birth Date Social Security No.

_____
(Current Address, City, State, Zip) (Current Phone)

To

GREATER AUSTIN NEUROLOGY CINIC
13915 N Mopac Expwy, Suite 302, Austin, TX 78728
Tel: 512-228-3800 Fax: 512-228-3801

Dates Requested: **From** _____ To: **Present**

Information to be released: (Reports may include information on drug/alcohol abuse, psychological/psychiatric diagnoses, and communicable diseases including HIV.)

- ☑ History & Physical
- ☑ Consultations
- ☑ Progress Notes
- ☑ Radiology/MRI/CT
- ☑ Laboratory studies
- ☑ HIV/AIDS, if applicable

Other _____

Purpose for release of information:

- ☑ Continuing Medical Care
- ☑ Insurance
- ☐ Social Security/ Disability
- ☐ Legal Purposes
- ☐ Personal Use
- ☐ Other _____

I understand that I may revoke this consent anytime except to the extent that action has already been taken before receipt of such revocation. This authorization expires automatically one hundred eighty (180) days from the date of signatures or earlier if otherwise specified. I understand that I may be charged for copies of my medical records. I understand that these records are protected under federal and state laws and cannot be disclosed without my consent except when required by law. I understand that the organization releasing my records will not be responsible for dissemination or disclosure of my confidential medical information when this clinic provides such information, at my request, to my health insurer, employer, attorney or other designee.

Patient's Name: _____ ✕_____
(Please print) (Signature of Patient or Guardian)

Date:_____