Authorization for Release of Information (To Southlake Neurology)

I hereby authorize ______________________________ ______________________________

Entity or Person from whom records are requested | Address

Telephone | Fax | City | State | Zip

to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. The protected health information to be disclosed is any and all medical records about health status, provision of health care, or payment for health care that can be linked to a specific individual. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

Patient Name (please print) | Date of Birth | Social Security Number

Patient Address (City, State and Zip) | Phone Number

Specific Date(s) of Service (if known)

Information to be released:

- **Complete Medical Records**
- Radiology Reports
- Registration Records
- Billing Records
- Visits & Encounters
- Laboratory Reports
- Consultation Reports
- Other: ______________________________

Description of the purpose of the use and/or disclosure:

The health information described herein shall be **released to:**

Southlake Neurology and Neurophysiology Clinic, PLLC
Name of Person or Entity (please print)

817-421-2905
Phone Number

321 West Southlake Blvd Suite 180 Southlake, Texas 76092
Address (City, State, and Zip)

817-416-7284
Fax Number

Delivery Method: ○ Mailing Address ○ Fax ○ Pick-Up Records ○ Other______________________________

This authorization shall be in force and effect until I revoke it, at which time this authorization to use or disclose this protected health information expires. I further understand that I may revoke this authorization at any time by notifying our practice in writing. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient, Parent, or Legal Guardian | **Date**

Printed Name of Patient, Parent, or Legal Guardian

Relationship to Patient **or** **Legal Authority** (Attach Supporting Documentation)