Authorization for Release of Information (From Southlake Neurology)

I hereby authorize Southlake Neurology and Neurophysiology Clinic, PLLC 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:**

Category: Hospital Physician Insurance Company Attorney Patient Other_____

Name of Person or Entity (please print) _____ Phone Number _____

Address (City, State, and Zip) _____ 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) _____

Please be aware there may be a charge for medical records depending on the type and amount of records being requested.