NEUROLOGY ASSOCIATES

255 E. Sonterra Blvd. Ste. 211, San Antonio, TX. 78258 PH#210-656-2333; Fax 210-656-1333

AUTHORIZATIONS TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name:_____ **Date of Birth:**_____ **Soc. Sec. #**_____

I authorize the following individual or organizations to disclose the above named individual's health information:

Name/Facility:_____

Address:_____

Phone #:_____ **Fax #:**_____

This information may be disclosed to **NEUROLOGY ASSOCIATES: 255 E. Sonterra Blvd. Ste. 211, San Antonio, TX. 78258**

For the purpose of:_____

Please Release the following:

___Problem List	**___X-Ray/Imaging reports from (date)_____to (date)_____**
___Progress Notes	**___X-Ray/Imaging films**
___History/Physical Exam	**___Laboratory results from (date)_____ to (date)_____**
___Medication List	**___EKG reports**
___Immunization Records	**___Genetic testing information**
___List of Allergies	**___Other Diagnostic Reports (Specify)_____**
___Neuropsychological Testing Results	**___Other (Specify)_____**

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____**Yes**, I consent to the release of this information. _____**No**, I do not consent to the release of this information.

I understand that the information release is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocations will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact Janis Adkins business/office manager of Neurology Associates.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

Relationship to Patient (If Legal Representative) **Witness**

COMPLETE ONLY IF INFORAMTION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Neurology Associates liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to patient (If Legal Representative) Witness