NEUROLOGY ASSOCIATES
AUTHORIZATIONS TO DISCLOSE HEALTH INFORMATION

255 E. Sonterra Blvd #211 San Antonio, Texas 78258 Tel:210-656-2333 Fax:210-656-1333

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

Patient Name________________________ **Date of birth**_________ **Soc. Sec. #**__________________

I authorize Neurology Associates to disclose the above named individual's health information:

This information may be disclosed ____

Address____**Fax#:**________________________

For the purpose of: ____

Please release the following:

- __**Problem List**
- __**Progress notes**
- __**History/Physical exam**
- __**Medication list**
- __**Immunization Record**
- __**List of Allergies**
- __**X-Ray/Imaging reports from (date)** ________**to (date)** ________
- __**X-Ray/Imaging films**
- __**Laboratory results from (date)** ________**to (date)** ________
- __**EKG reports**
- __**Genetic testing information**
- __**Other Diagnostic Reports (Specify)** ______________________
- __**Other (Specify)** ____________________________________

I understand that the information in my health record may include information relating to sexually transmitted disease. , 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 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 any time. 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 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 my not be protected by federal confidentiality rules. I may contact Janis Adkins officer manager of Neurology Associates if I have questions about the disclosure of my health information.

____________________________________ ____________________________
Signature of Patient or Legal Representative **Date**

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

COMPLETE ONLY IF INFORMATION 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 mad 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 of Legal Representative Date

____________________________ __________________________
Relationship to Patient (If Legal Representative) Witness

Date request completed__________________ # pages copied__________ Reviewed only____________

Charges $_______________ Cash ____________ Check # ___________Credit Card______________Initials____________