AUTHORIZATION TO RELEASE HEALTH INFORMATION

PLEASE COMPLETE ENTIRE FORM

Name of Provider/Facility: I hereby authorize _____ to release health records information:

Address _____ City _____ State ____ Zip _____

Office Phone # _____ Fax # _____

Patient Name:_____ Date Of Birth:_____

Patient Phone Number - Home _____ Cell _____

For Healthcare Covering the Periods from _____ To _____ **OR** _____ all dates

Purpose of release _____

PLEASE RELEASE RECORDS TO: **Woodlands Neurology Clinic**
129 Vision Park, Suite 201
Shenandoah, TX 77384
Phone: 936-267-0912
Fax: 855-710-5854

Please release:

☐ Complete record ☐ Lab reports ☐ Imaging reports ☐ Pathology reports

☐ Other _____

☐ I do ☐ I do not (check applicable box) authorize this information to be faxed. If yes:

Fax Number: _____ Name of Person to Receive Fax_____

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

REVOCATION: I understand that this authorization maybe revoked in writing at any time, except the extent that actions have already been taken in response to this authorization for the purposes stated above.

Unless otherwise indicated, this authorization will expire in ninety (90) days from date of signature. The physician and employees are released from any legal responsibility or liability for disclosure to the above information to the extent indicated and authorized herein.

Medical care is not conditional upon the signing of this authorization**.**

WARNING: Your Personal Health Information (PHI) may be re-disclosed by the receiving entity.

I understand that there may be a fee for preparing and furnishing this information

_____	_____	_____
Signature of Patient or Legal Representative	**Relationship to Patient**	**Date**

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

I understand that my medical records 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 _____ liable for any misinterpretation of the information in my medical record as result of not consulting my physician for the correct interpretation.

_____	_____	_____
Signature of Patient or Legal Representative	Relationship to Patient	Date

TO BE COMPLETED BY WOODLANDS NEUROLOGY STAFF ONLY!

Date request completed _____ # pages copied _____

Send out by _____ *Method* _____Mailed _____Faxed _____ Picked up_____