Neurology Clinic
224 Hunters Village
New Braunfels, TX 78132
830-606-9142 Fax 830-608-9701

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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

Patient Name_____ Medical Record #_____

Date of Birth_____ Social Security#_____ (optional)

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

_____ Address:_____

This information may be disclosed TO and used by the following individual or organization:

_____ Address:_____

For the purpose of:_Treatment and Follow-up_____

Please release the following:

____Problem List	__X-Ray/Imaging Reports-from (date)_____ to (date)_____
____Progress Notes	__X-Ray Films
____EKG Reports	__ Laboratory Results - from (date)_____ to (date)_____
____Medication List	__History/Physical Exam
____Immunization Record	__Genetic Testing Information
__ __List of Allergies	__Other Diagnostic Reports (Specify)_____
__ __Other_____	

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 realease of this information.

I understand that the information released 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 my insurance company when the law provides my insurance 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 to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact Caroline Brewer.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature to Patient (if Legal Representative) Date

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 made in my medical record to prevent my misunderstanding of the information contained in my entries. I will not hold_____ 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

_____ _____
Signature to Patient (if Legal Representative) Date