DFW NEUROLOGY, PLLC.

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PATIENT AUTHORIZATION TO OBTAIN MEDICAL RECORDS FROM THIRD PARTIES

By signing this authorization, I authorize the following third party to disclose certain protected health information (PHI) about me to DFW Neurology PLLC:

Name of third party (Doctor/Provider): _____

Street Address or PO Box: _____ Suite: _____

City/State: _____Zip: _____

Phone: _____ Fax: _____

This authorization permits the above listed third party to disclose my PHI to DFW Neurology PLLC the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

_____

_____

This authorization will expire on: _____ (Expiration Date or Defined Event)
When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the above listed third party has acted in reliance upon this authorization.

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

_____
Patient SSN & DOB