DFW NEUROLOGY, PLLC

6800 HARRIS PKWY, SUITE 100
FORT WORTH, TEXAS 76132
PHONE: (817) 292-0088 **FAX:** (817) 292-8288 OR (855) 285-0906

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.).

_____

AUTHORIZATION TO RELEASE MEDICAL RECORDS **TO** THIRD PARTIES

By signing this authorization, I authorize DFW Neurology PLLC to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits DFW Neurology PLLC to use or disclose my PHI to:

_____

_____

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 DFW Neurology PLLC has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer of DFW Neurology PLLC located at the address listed above.

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