



Authorization for Release of Patient Health Information

BELLAIRE NEUROLOGY, 6565 WEST LOOP SOUTH, SUITE 401, BELLAIRE, TX 77041 • (713) 715-6360 PHONE • (713) 715-6367 FAX

PLEASE PRINT OR TYPE:

Patient Name: _____
Address: _____
Phone: _____

Birth Date: _____
Social Security #: _____

I authorize _____, to release the patient health information of the named patient above
Name of Facility or Person

to: _____
Name & Address of person or organization to which disclosure is to be made

Phone: _____ Fax: _____

I understand that this information will include, where applicable, test results about HIV/AIDS, alcohol, or drug abuse. I understand that this information may be sent by telephone, facsimile, or electronic means and that reasonable efforts will be made to protect confidentiality.

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

Description of information to be released: _____ **SPECIFY TREATMENT DATES:** _____ **to** _____
(CHECK ALL THAT APPLY)

<input type="checkbox"/> Pertinent Information	<input type="checkbox"/> Phone Notes	<input type="checkbox"/> Therapy Reports	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Email Correspondence	<input type="checkbox"/> Radiology Reports	_____
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Billing Records	_____
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Laboratory Reports (including HIV/AIDS)	<input type="checkbox"/> Entire Medical Record	_____

This information is being released for the purpose of (CHECK ALL THAT APPLY)

Continuing Care Legal Other: _____
 Reimbursement Personal, for own purposes (requested by patient)

Expiration Date or Event: I understand that failure to provide an expiration date or event in the space provided below will result in this authorization expiring 180 days from the date that it is signed.

Expiration Date or Event: _____

- I understand that I may revoke this Authorization at any time. Revocation does not affect information released prior to the date of revocation. To revoke this Authorization, please send written notice to the organization named above.
- I understand that my treatment and the payment for my health care will not be affected if I do not sign this form.
- I understand that I may inspect and copy the information described on this form upon request.
- I understand that I will receive a copy of this form after I sign it.
- I understand that the above named organizations are relieved of responsibility or liability for release of the information, once the information has been released to the designated recipients.

Signature of patient or legal representative

Authority or Relationship to Patient (If Applicable)

Date

Signature of Witness

Witness Name

Date

FOR STAFF USE ONLY:

Will direct or indirect compensation, of any kind, be received for using or disclosing the health information described above? Yes No

Inspection Copying Payment amount rec'd \$ _____ Payment received from: _____
Request for inspect or copy: Accepted Denied Date: _____ Comments: _____