PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Texas NeuroRehab Center, 1106 W. Dittmar Rd. Austin, Texas 78745
Phone: 512-444-4835 Fax: 512-462-6771

Patient Name:____ Date of Birth:_____/_____/_____

Address:____City:_______________________State:_______Zip:______________

E-mail Address:____ Phone:____

I hereby freely and voluntarily authorize Texas NeuroRehab Center to (check box below):

☐ **Release/disclose my protected health information to:** **OR** ☐ **Obtain my protected health information from:**

Individual/Facility/Organization:____

Address:____City:________________________State:_______Zip:___________________

E-mail Address:_______________________________________ Phone:______________________ Fax:___________________________

The purpose of this disclosure is for: ☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care

Information to be used or disclosed: ☐ Discharge summary ☐ Psychiatric Evaluation ☐ History & Physical ☐ Verbal Exchange of Information ☐ Treatment Plan(s) ☐ Lab/Radiology reports ☐ Psychosocial assessment ☐ Immunization Record ☐ Entire Record ☐ Consultations ☐ Neuropsychological Assessment ☐ Test Result (s) of:____

☐ Other (explain) ____

Covering the period of healthcare from: Specific Date(s):______________to_______________**OR** ☐ All past, present, and future encounters/visits

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired or mental health services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released (include dates where appropriate):

Alcohol, Drug, or Substance abuse Records ☐ Yes ☐ No Dates:______________________
HIV Testing and Results ☐ Yes ☐ No Dates:______________________
Mental Health Records ☐ Yes ☐ No Dates:______________________
Psychotherapy Records ☐ Yes ☐ No Dates:______________________

Disclose Format: ☐ US Mail ☐ Fax ☐ E-mail ☐ Other:______________________________

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 1106 W. Dittmar Rd., Austin, TX 78745. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition:______________________. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

____ _____________
Patient Signature *Date*

____ _____________ ________________________________
Guardian or Representative Signature *Date* *Relationship to Patient*

____ _____________
Witness Date

(For Office Use Only)
*Date Received:*____________________________ *ROI completed on:*__________________________________