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

In order to comply with your request, please fill out this form entirely, otherwise the form will not be considered valid. Much of the information is REQUIRED by federal and state law. Please print.

Patient Name:______________________________________ Date of Birth:____/____/____
Address:______________________________City:__________________State:______Zip:____________
E-mail Address:______________________________ Phone:______________________________

I hereby freely and voluntarily authorize Texas Neuro Rehab Center to Release/disclose or obtain my protected health information to:

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 ☐ No ☐ Yes Dates:____________________
HIV Testing and Results ☐ No ☐ Yes Dates:____________________
Mental Health Records ☐ No ☐ Yes Dates:____________________
Psychotherapy Records ☐ No ☐ Yes 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.

***NOTE:** The signature of the patient or his or her personal representative (someone who has legal authority to act on the patient's behalf) is necessary. A parent must sign for a minor dependent child.*

*Signature of Patient:*______________________________ *Date:*__________________________

Signature of Personal Representative:______________________________ Date:____________________

☐ **Parent** ☐ **Legal Guardian*** ☐ **Medical Power of Attorney*** ☐ **Other***______________________________

**Must provide documentation supporting your legal authority to act on the patient's behalf.*

Witness Signature:______________________________________ Date:____________________