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 Information

Patient Name:			Date of Birth:
Street Address:	City:	State:	Zip:

Where do you want the records sent?

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

Individual/Facility/Organization:			
Street Address:	City:	State:	Zip:
E-mail Address:	Phone:	Fax:	

How would you like your records delivered?

☐ US Mail ☐ Fax ☐ In-person pick up ☐ E-mail Address:_____

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

What information would you like to be disclosed/released?

☐ Discharge summary ☐ History & Physical ☐ Psychiatric Evaluation ☐ Neuropsychological Assessment ☐ Verbal Exchange of Information
☐ Test Results of (please specify):_____
☐ Other (explain): _____

Covering the period of healthcare from: Date(s) of Service:_____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.

* If you wish for Drug/Alcohol Abuse information to ***NOT*** be released, please sign and date here:_____

* If you wish for HIV information to ***NOT*** be released, please sign and date here:_____

* If you wish for mental health information to ***NOT*** be released, please sign and date here:_____

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:_____