Chart # _____

Austin Neurological Clinic
Medical Records Release Form

Patient Name : _____ **DOB:** _____

SS#: _____ **Doctor:** _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

☐ Dictation only (no charge)

☐ Complete record ($25.00 for first 20 pages, $.50 per page thereafter)

☐ Records of care from the following dates: _____ to _____

☐ Records concerning the following condition: _____

☐ Other, please specify _____

☐ Confer with person listed below orally about my medical information

Release my protected health information:

From	**To**
Name: _____	**Name:** _____
Street: _____	**Street:** _____
City: _____ **State:** _____ **Zip:** _____	**City:** _____ **State:** _____ **Zip:** _____

Including information (if applicable) pertaining to:
_____**Mental Health** _____**Drugs/Alcohol** _____**HIV / AIDS:** I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

Initial: _____ **Date:** _____

Limitations on the information you may release subject to this Release Form are as follows:

_____

_____

The reasons or purposes for this release of information are as follows:

☐ Continued patient care ☐ Personal Use ☐ Insurance Claim/Application

☐ Disability Determination ☐ Attorney/Legal ☐ Other _____

I understand that I may revoke this authorization at any time. If I fail to specify an expiration date, this authorization will expire in six months. I understand that you will provide this information within 15 business days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness