



Authorization Form for Release and Disclosure of Protected Health Information

Patient Name: Date of Birth:
Address: Soc Sec #:
City: State: Zip: Phone:

I hereby authorize the release and disclosure of my protected health information to:

Name: Phone:
Address: Fax:
City State: Zip:

This information is necessary for the following purpose:

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.
I understand that this authorization is voluntary and I may refuse to sign this authorization. The authorization will expire by law 180 days from the date of this authorization unless I specify otherwise.
I further understand that I may revoke this authorization at any time by notifying NeuroTexas, PLLC. If I revoke this authorization, I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation does not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative
Printed Name of Patient of Patient's Representative

Date
Relationship to Patient