neurotexas, PLLC
Brain & Spinal Surgery

Authorization Form for the Release and Disclosure of Protected Health Information

Email: jbravo@neurotexas.net Fax: 512-474-1118

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State : _____

Zip Code: _____ Phone #: _____ Fax #: _____

I hereby authorize the release and disclosure of my protected health information to:
(choose one of the following options)

1. **Self:** ◯ to be mailed ◯ to be picked up at office ◯ to be faxed
2. **Other Physician(s):**

Name: _____ Phone #: _____

Address: _____ Fax #: _____

City: _____ State: _____ Zip Code: _____

Please send the following records: (check all that apply)

☐ Office Visit Notes ☐ Radiology Reports ☐ Operative Reports ☐ Other (Specify)

Date(s) of Service: _____ _____

I understand that the information in my health records 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. This authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. The authorization will expire by law 180 days from the date of this authorization unless I specify otherwise.

I understand that I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. I understand that NeuroTexas, PLLC charges a processing fee for this service. According to the regulations outlined by the Board of Medical Examiners and in compliance with Texas statute, a fee of $25.00 for the first 20 pages and $0.50 per page thereafter, plus postage will be charged for record requests.

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 will not affect any actions taken before the receipt of the written revocation.

_____ _____
Printed Name of Patient or Patient's Representative Date

_____ _____
Signature of Patient or Patient's Representative Relationship to Patient