This authorization may be used to permit Texas Neurology Center/Jennifer York, MD, (5750 Balcones Drive, Suite 110, Austin, TX 78731) to disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information. By law, records are to be provided within 30 calendar days of request.

|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT'S NAME:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **DOB:** | \_\_\_\_\_\_\_\_\_\_\_ |

**RELEASE MY RECORDS TO:**

|  |  |
| --- | --- |
| **Name of Medical Provider:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Complete Address:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Phone Number:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Fax Number:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**\*\***RECORDS WILL BE SENT BY FAX UNLESS LISTED PROVIDER IS UNABLE TO RECEIVE BY FAX OR OTHERWISE INDICATED BELOW:

[ ]  PLEASE SEND RECORDS BY MAIL TO MEDICAL PROVIDER'S ADDRESS LISTED ABOVE

**SPECIFIC INFORMATION TO BE DISCLOSED:**

[ ]  Medical Records only for specific date range:

|  |  |  |  |
| --- | --- | --- | --- |
|  FROM: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | TO: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

[ ] Entire Medical Record ONLY created by Dr. Jennifer York or ordered by Dr. Jennifer York, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, and consults.

[ ] Entire Medical Record, including patient histories, office notes (except for psychotherapy notes), test results, radiology studies, films, referrals, consults, and records received from OTHER HEALTH CARE PROVIDERS.

[ ] Other (for example: Sleep Study Report Only)

|  |
| --- |
| ­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PLEASE INITIAL NEXT TO THE ITEMS YOU WANT INCLUDED BELOW:**

|  |  |
| --- | --- |
| \_\_\_ | Drug, Alcohol or Substance Abuse Records |
| \_\_\_ | Mental Health Records (Except Psychotherapy Notes) |
| \_\_\_ | HIV/AIDS-Related Information (including HIV/AIDS Test Results) |
| \_\_\_ | Genetic Information (Including Genetic Test Results) |

**REASON FOR RELEASE OF INFORMATION:**

[ ]  Treatment/Continuing Medical Care

|  |  |
| --- | --- |
| [ ]  Other | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 **The individual signing this form agrees and acknowledges as follows:**

**(1) VOLUNTARY AUTHORIZATION:**

This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

[ ]  I have read the above.

**(2) RIGHT TO REVOKE:**

I understand that I have the right to revoke this authorization at any time by writing to Texas Neurology Center/Jennifer York, MD. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

[ ] I have read the above.

**(3) EFFECTIVE TIME PERIOD:**

|  |  |
| --- | --- |
| EXPIRATION DATE OF THIS REQUEST (MM/DD/YYY) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

[ ]  I have read the above.

**(4) SPECIAL INFORMATION:**

This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETC INFORMATION only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines above, I specifically authorize release of such information to the person indicated herein.

[ ]  I have read the above.

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**(5) RESPONSE TIME:**

Records requests are required by law to be completed within 30 calendar days from date of receipt. Our office can generally respond same day or between 48 - 72 hours (accounting for weekends and office closures).

[ ]  I have read the above.

**(6) SIGNATURE AUTHORIZATION:**

I have read this form and agree to the uses and disclosures of the information as described. The parties agree that electronically typed signatures/initials appearing on this release form are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT OR PARENT/GUARDIAN SIGNATURE:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **DATE:** | \_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **IF PARENT OR GUARDIAN, please list relationship ot Patient:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

|  |  |  |  |
| --- | --- | --- | --- |
| **SIGNATURE OF MINOR (IF APPLICABLE):** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **DATE:** | \_\_\_\_\_\_ |

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