AUTHORIZATION TO RELEASE HEALTH INFORMATION
PLEASE COMPLETE ENTIRE FORM

Name of Provider/Facility: I hereby authorize **WOODLANDS NEUROLOGY CLINIC** to release health records information on:

Patient Name:_____   Date of Birth:_____

Patient Phone Number Primary#:_____ Secondary#:_____

For Healthcare Covering the Periods from _____To:_____ OR _____ all dates For

the purpose(s)of: _____

PLEASE RELEASE RECORDS TO:

Name of Provider/Facility _____

Address: _____

City:_____ State: _____ Zip:_____ **Phone Number**:_____

Please release:

☐ Complete record   ☐   Lab reports   ☐ Imaging reports   ☐ Pathology reports

☐ Other _____

☐ I do ☐ I do not (check applicable box) authorize this information to be faxed. If yes:

Fax Number: _____ Name of Person to Receive Fax_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

___**Yes**, I consent to the release of this information. ___ **No**, I do not consent to the release of this information.

REVOCATION: I understand that this authorization maybe revoked in writing at any time, except the extent that actions have already been taken in response to this authorization for the purposes stated above.

Unless otherwise indicated, this authorization will expire in ninety (90) days from date of signature. The physician and employees are released from any legal responsibility or liability for disclosure to the above information to the extent indicated and authorized herein.

Medical care is not conditional upon the signing of this authorization.

WARNING: Your Personal Health Information (PHI) may be re-disclosed by the receiving entity.

I understand that there may be a fee for preparing and furnishing this information

_____   _____   _____
Signature of Patient or Legal Representative   Relationship to Patient   Date

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COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold _____ liable for any misinterpretation of the information in my medical record as result of not consulting my physician for the correct interpretation.

_____   _____   _____
Signature of Patient or Legal Representative   Relationship to Patient   Date

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TO BE COMPLETED BY WOODLANDS NEUROLOGY CLINIC STAFF ONLY:

Date request completed _____ # pages copied _____

Send out by _____ Method _____Mailed _____Faxed _____ Picked up