

Authorization for Release and Disclosure of Protected Health Information

Indicate the name of physician, hospital, medical center, or lab that you are requesting records from:

Name of entity to release information

Phone number

Address

Fax number

City/State/Zip

I am requesting that the medical information for the patient name listed below be transferred to (preferably via fax):

**Austin Neuromuscular Center
Yessar Hussain, M.D.
3901 Medical Parkway, Suite 300
Austin, TX 78756
512-920-0140 p / 512-920-0142 f**

Please release the following information:

___ Complete Medical Record

___ Other - please specify _____

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

Signature of Patient or Legal Guardian

Relationship to Patient

Patient's Printed Name

Patient's Date of Birth

Date of Signature

