AUSTIN
NEUROMUSCULAR
CENTER

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's name listed below be transferred to (preferably via fax):

Austin Neuromuscular Center
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