AUSTIN
NEUROMUSCULAR
CENTER

AUTHORIZATION FOR THE RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION-INCOMING

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

____

Name of entity to receive information

____

Address (number, street, city, state, zip)

______________________ ______________________

Phone Fax

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

Austin Neuromuscular Center
4705 Spicewood Springs Road
Austin, TX 78759
Phone: 512-920-0140 Fax: 512-920-0142

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

______________________ ______________________

Name Date of Birth

____

Date of Signature