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**
**Attn: Medical Records**
**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