AUSTIN
NEUROMUSCULAR
CENTER

Authorization for
Release and Disclosure of Protected Health Information

Indicate the name of the 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 above 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

_____ _____

Patient's Printed Name Patient's Date of Birth

_____

Date of Signature