AUSTIN
NEUROMUSCULAR
CENTER

AUTHORIZATION FOR THE RELEASE & DISCLOSURE OF PROTECTED HEALTH INFORMATION - OUTGOING

By signing this authorization, I authorize Austin Neuromuscular Center physicians & associates to release and disclose protected information about me to:

_____

Name of entity to receive information

_____

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

_____

Phone Fax

This authorization permits Austin Neuromuscular Center physicians & associates to use and/or disclose the following individually identifiable information about me: (specifically describe the information to be used or disclosed, such as date(s) of services, types of services, test results, etc.).

_____

_____

This information is necessary for the following purposes:

☐ Continuing Patient Care ☐ Insurance ☐ Personal Use ☐ Attorney/Legal
☐ Other (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. I understand that this information will be provided within five business days from receipt of the request and that a fee for preparing and furnishing this information may be charged according to the ruling set forth by the Texas State Board of Medical Examiners.

_____

Signature of Patient or Legal Guardian Relationship to Patient

_____

Name Date of Birth

_____

Date of Signature

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