



AUTHORIZATION FOR THE RELEASE AND 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 purpose:

- 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