AUSTIN
NEUROMUSCULAR
CENTER

MEDICAL RECORDS RELEASE FORM

By signing this authorization, I authorize Austin Neuromuscular Center and Yessar Hussain, M.D. to release and disclose protected information about me to:

_____

Name of entity to receive information

_____

Address

_____ _____

Phone Fax

This authorization permits Austin Neuromuscular Center and it's providers 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 you will provide this information within five business days from receipt of request and that a fee for preparing and furnishing this information may be charged according to ruling set forth by the Texas State Board of Medical Examiners.

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Patient's Printed Name Patient's Date of Birth

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