## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMAION

**NAME OF PATIENT OR INDIVIDUAL**:

______________________________________________________________________________

**Last** **First** **Middle**

**DATE OF BIRTH**: Month __________ Day __________ Year __________

**ADDRESS**:_____________________________________________________________________________

**CITY**: __________________________________________ **STATE**: _______________ **ZIP**: _____________

**PHONE**: (______) _________________________ **EMAIL ADDRESS**: ________________________________

### AUTHORIZATION

**I AUTHORIZE THE FOLLOWING INDIVIDUAL OR ORGANIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION REGARDING THE ABOVE NAMED PATIENT:**

Person/Organization Name: ________________________________________________________________

Address: ____________________________________________________________________________

Phone: ____________________________ Fax: ___________________________

Reason for request: ______________________________________________________________________

Dates of Service: ___________________________________

### PLEASE RELEASE THE FOLLOWING INFORMATION:

- Entire Record
- Progress/Consultation Notes
- Lab Results
- Diagnostic Test Reports

**THIS INFORMATION CAN BE RELEASED TO:**

Houston Area Pediatric Neurology, PLLC

Phone: 832-471-6248 Fax: 832-471-6984

Katy Location:
24514 Kingsland Blvd
Katy, TX 77494

Friendswood Location:
1560 W Bay Area Blvd, Suite 270
Friendswood, TX 77546

**SIGNATURE X**_______________________________________________________ ___________

**Signature of Individual or Individual's Legally Authorized Representative** **DATE**

Printed Name of Legally Authorized Representative (if applicable): ____________________________

If representative, specify relationship to the individual: ______________________________________