AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

NAME OF PATIENT OR INDIVIDUAL:

_____

Last **First** **Middle**

DATE OF BIRTH: Month _____ Day _____ Year _____

ADDRESS:_____

CITY: _____ **STATE**: _____ **ZIP**: _____

PHONE: (_____) _____ **ALT. PHONE**: (_____) _____ _

EMAIL ADDRESS: _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Organization Name: Houston Area Pediatric Neurology

Katy Location:
24514 Kingsland Blvd
Katy, TX 77494

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

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name: _____

Address: _____

City: _____ **State**: _____ **ZIP**: _____

Phone: (_____) _____ **Fax**: (_____) _____

WHAT INFORMATION CAN BE DISCLOSED?

- All health information
- Progress/Consultation Notes
- Lab Results
- Diagnostic Test Reports
- Billing Information
- Other_____

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: _____