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
24514 Kingsland Blvd
Katy, TX 77494
Phone: 832-471-6248
Fax: 832-471-6984

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: ____________________________________