SOUTHWESTERN NEUROSCIENCE INSTITUTE

Authorization for Release of Information

I hereby authorize **Southwestern Neuroscience Institute** at 1215 Kinwest Pkwy Ste 120 Irving TX 75063, Phone: 214-496-0500, Fax: 214-496-0922 to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcoholic dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my healthcare and the payment of my healthcare will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-healthcare provider, the release information may no longer be protected by federal and state privacy regulations.

_____

Print patient name | Date of birth | Social security number

Dates(s) of service (if known): _____

Description of Information to be released: (Check all that apply)

Emergency Room	Radiology reports	Admission/Registration	Other
History&Physical	Consultation reports	Records	_____
Nurse' notes	Physician's orders	Laboratory Results	_____
Progress notes	Operative records	Billing records	_____
Discharge Summary	Radiology films		

Description of the purpose of the use and/or disclosure:

_____

_____

The health information described herein shall be released to: _____Hospital; _____Physician; _____Insurance; _____Attorney; _____Patient; _____Other(check the appropriate category)

_____

Physician Name | Address | City | State | Zip

I understand that this authorization will expire by law in 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____(expiration event/date).

I further understand that I may revoke this authorization at any time by notifying the office of Southwestern Neuroscience Institute in writing to 1215 Kinwest Pwy Ste 120 Irving TX 75063. I also understand that the written revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____

Signature of Patient or Patient's Representative | Date

_____

Printed Name of Patient's Representative

_____ _____

Relationship to Patient | Legal Authority (attach supporting documentation)