Authorization for the Release and/or Discussion of Protected Health Information

Patient Name:_____ SS#: _____-_____-_____Birth Date: ___/____/_____

Authorization
1. I, _____, hereby authorize
(Name of Patient or Patient's Legally Authorized Representative)

2. Name of person or

organization:_____

Street Address: _____

City, state, zip:_____ Telephone: ( )

3. **A.** To release and/or discuss the following information

Complete Record Outpatient Care Inpatient Care X-Ray Results Laboratory Results

Treatment Plan Update Other
_____

If my record contains the following information, it is also released if *CHECKED* in boxes below:
Substance Abuse Mental Health Treatment HIV Testing or Treatment

4. To: Southwestern Neuroscience Institute
1215 Kinwest Parkway Suite 120
Las Colinas, Irving, TX 75063
Phone (214) 496-0500
Fax (214) 496-0922

5 Signature:
I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.
I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.
This authorization expires one (1) year from today's date, or upon the following specified event:
_____.

I authorize the use of a copy of this form for the disclosure of the information described above.

Signed _____ Relationship_____ Date: ____/____/____