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Medical Records Release Form

Chart #_____ Doctor_____

Patient Name: _____ DOB: _____

By signing this form, I authorize the release of confidential health information about me to the person(s) or entity listed below.

I hereby authorize Austin Neuropsychology, PLLC to:

Obtain health information from ☐ Send health information to ☐

Name: _____
Street Address: _____
City, State and Zip: _____
Phone #_____ Fax # _____

Including information (if applicable) pertaining to:

☐ Dictation only

☐ Complete Record

☐ Records of care from the following dates: _____

☐ Neuropsychology report and scores

☐ Confer with the person listed above orally regarding my medical information

I understand that I may revoke this authorization at any time. This authorization is valid indefinitely until cancelled by me, unless otherwise specified. I understand that when Austin Neuropsychology is releasing information to an outside person/entity, this information will be provided within 15 business days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Unless specifically restricted, this release encompasses entire record including information pertaining to mental health, drug/alcohol use and HIV/AIDS.

I wish to restrict release of the following types of information:

_____

_____

_____ _____

Signature of patient or legal representative Date

_____

Relationship to patient