Instructions for completing the AUTHORIZATION TO DISCLOSE HEALTH INFORMATION sheet.

This form allows Dr York to request medical records and to access other information (CPAP downloads, etc) from health companies.

To complete, ONLY sign and date the form at the bottom, and return it by either attaching it to a message via the portal or by fax (512-744-1654).

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record # _____

Date of Birth _____ Social Security # _____(optional)

I authorize the following individual or organization to disclose the above named individual's health information:

_____ Address:_____

This information may be disclosed TO and used by the following individual or organization:

Texas Neurology Center (Office of Jennifer York, MD) Address: 5750 Balcones Dr, Suite 110, Austin, TX 78731

Fax Number: 512-744-1654 **For the purpose of**: Continuity of Care

Please release the following:

___Entire Record

or:

___Problem List
___Progress Notes
___History/Physical Exam
___Medication List
___Immunization Record
___List of Allergies
___X-Ray/Imaging Reports-from (date)_____ to (date)_____
___X-Ray Films
___Laboratory Results-from (date)_____to (date)_____
___EKG Reports
___Genetic Testing Information
___Other Diagnostic Reports (Specify)_____
___Other (Specify)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
___**Yes**, I consent to the release of this information. ___ **No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:_____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact _____*(insert privacy officer or other office or individuals name or contact information)*

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

Date request completed_____ # pages copied_____ Reviewed only_____
Charges $_____ Cash_____ Check #_____ Initials_____