

**Authorization for Neurological Clinic of Texas, PA
To Obtain Protected Health Information**

I authorize Neurological Clinic of Texas, PA, its physicians, and its staff to receive / disclose
the following protected health information from the facility below:

Dr's Name Medical Records Being Released From: _____

Dr.'s Address: _____

Patient's Name _____ DOB _____

The protected health information to be disclosed to Dr. _____

This protected health information is being used or disclosed for the following purpose
(or "at the request of the individual"). You must fill in something.

- This authorization shall be in force for one year after I sign it.
- The information may include information on HIV, AIDS, alcohol use, drugs and mental health.
- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at 7777 Forest Lane B116 Dallas, Texas 75230. A revocation is not effective to the extent that a person has relied on it for use or disclosure of the protected health information, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- Neurological Clinic of Texas, PA will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the request use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority