Child Neurology
Consultants of Austin

Authorization For Use & Disclosure Of Protected Health Information

Patient's Name: _____ Date of Birth: _____ SSN: _____

Address: _____ Contact Phone: _____

City: _____ State: _____ Zip: _____ Alternate Phone: _____

Please release records ❑ To ❑ From: Provider Name: _____

Address: _____ Contact Phone: _____

City: _____ State: _____ Zip: _____ Fax Number: _____

Release my records ❑ To ❑ From: Child Neurology Consultants of Austin – Central Austin Clinic

Address: 7940 Shoal Creek Blvd., Suite 100 Contact Phone: (512) 494-4000

City: Austin State: TX Zip: 78731 Fax Number: (512) 494-4024

Information Requested:

❑ Complete Medical Record
❑ History/Physical
❑ Immunizations
❑ Labs
❑ Medication List & Problem List
❑ EKG/EEG Reports
❑ Radiology Reports
❑ Progress/Dr. Note (last three months)
❑ Pathology Reports
❑ Other: _____

Purpose of Requested Use of Disclosure:

❑ At the request of the individual
❑ Continued medical care
❑ Legal
❑ Other: _____

❑ Date(s) of Treatment: _____

I understand that you will provide this information within 15 days from the receipt of the request (per Medical Practice Act of the Texas Medical Board) and that a fee for preparing and furnishing this information may be charged if the records are being released to the patient for personal use. This authorization expires 60 days from the Date of Authorization or _____/_____/_____ .

By signing this authorization, I authorize the use and disclosure of my Protected Health Information as requested. I understand that the information may be re-disclosed by the recipient and may no longer be protected by federal HIPPA privacy rule. I do not have to sign this authorization in order to receive treatment from Child Neurology Consultants of Austin. I have the right to revoke this authorization in writing except to the extent that the Association has acted in reliance upon this authorization.

Patient/Parent/Legal Guardian Signature: _____

Date: _____ Relationship to Patient: _____

For Office Use Only:

Date of Authorization: _____ Witness: _____