Patient Centered Neurology

915 Gessner Rd., Suite 750 Houston, TX 77024

www.pcneuro.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____Date of Birth: _____
Address: _____
Phone #: _____

☐ **TO**
☐ **FROM**

Physician: _____
Facility: _____
Address: _____
City, State, Zip: _____
Fax #: _____
Phone #: _____

☐ **TO**
☐ **FROM**
Patient Centered Neurology
915 Gessner Rd. Ste 750
Houston, TX 77024
P: 713-333-6900
F: 713-333-6919

Information requested:

- ☐ All Medical Records
- ☐ Laboratory Reports
- ☐ Radiology Reports: _____
- ☐ Drug, Alcohol, Mental, Behavioral, Psychiatric
- ☐ Other: _____

Terms of Authorization: I understand that fees may apply. I also understand this authorization may be revoked in writing at anytime, according to the instructions in Patient Centered Neurology Notice of Privacy Practices, except to the extent that action had been taken in reliance on this authorization. If the person or entity that received the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral or psychiatric care. Patient Centered Neurology will not condition treatment or payment on my completion of this form.

Signature: _____Date: _____

Printed Name: _____Relationship to Patient: _____