

**DALLAS PEDIATRIC NEUROLOGY ASSOCIATES**

Kazi Imran Majeed, M.D.  
AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY  
WITH QUALIFICATION IN CHILD NEUROLOGY  
8390 LBJ Freeway 10th Floor  
Dallas, Texas 75243

469-902-0020 FAX 469-902-0021

**AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

**I hereby authorize:** Dallas Pediatric Neurology Associates

**To release to:** \_\_\_\_\_

Recipient Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone#

\_\_\_\_\_  
Fax#

\_\_\_\_\_  
City, State, Zip

**THE FOLLOWING INFORMATION FROM THE MEDICAL RECORD OF:**

Patient Name \_\_\_\_\_

Patient Address \_\_\_\_\_

Telephone # \_\_\_\_\_

DOB: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

Office Notes  Hospital Records  Labs  Complete Chart

EEG  CD  Report Only  Other, Specify \_\_\_\_\_

Radiology Reports  CD  Report Only

**THE INFORMATION SPECIFIED ABOVE IS TO BE RELEASED FOR THE FOLLOWING PURPOSE:**

Treatment/Consultation – Did we refer you for this consultation?  yes  no

Patient Request  Billing or Claims  Social Security

Other, specify:

Substance Use/Abuse Treatment, Psychiatric, Genetic Testing, and/or HIV/AIDS Records  
Release Federal and State Law requires specific authorization from patients/parents to release  
sensitive information. I understand that if my medical or billing record contains information in

reference to drug, tobacco and or alcohol use/abuse, psychiatric care, genetic testing, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS testing and/or treatment, and/or other sensitive information, I must specifically agree to its release by checking Yes or No in the appropriate box. (TX HB 300)

Substance use or abuse treatment  YES-DISCLOSE  NO-DO NOT DISCLOSE

Psychiatric Care and/or mental health records  YES-DISCLOSE  NO-DO NOT DISCLOSE

Genetic Testing  YES-DISCLOSE  NO-DO NOT DISCLOSE

HIV/AIDS testing and/or treatment  YES-DISCLOSE  NO-DO NOT DISCLOSE

**TIME AND LIMIT TO REVOKE**

I understand this authorization will be valid for 180 days from the date signed to release any records created up to the date of signature unless revoked prior to that time or unless otherwise specified as follows. Any records created after the date of this authorization will require a new authorization. I desire this authorization be in effect until \_\_\_\_\_.

**Authorization and Re-disclosure**

I understand that his authorization is voluntary and I may refuse to sign it. I further understand that my health care and the payment of my healthcare may not be conditioned on whether I sign the authorization form. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal and state privacy regulations. I authorize the medical facility to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for reproduction of record copies and/or CD/s. A copy or facsimile of this authorization is as valid as the original.

**Preferred Method of Reproduction:**  CD  Paper  Fax  Pick Up in Office

---

*Signature of Patient, Parent or Legal Representative*

---

*Date*

---

*Authority to sign if not patient (Documentation may be required)*