DALLAS PEDIATRIC NEUROLOGY ASSOCIATES
SUBSIDIARY OF CHILD NEUROLOGY CLINICS OF TEXAS
7777 Forest Lane, Suite B248
Dallas, TX 75230-2507
972-566-8600 FAX 972-566-8601

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)