# Authorization to Disclose Health Information

**I hereby authorize the use or disclosure of information from the medical record of**:

Patient Name_____ Date of Birth_____

**I authorize the following individual or organization to disclose the above named individual's health information:**

Neurosurgical Associates of San Antonio, P.A.
4410 Medical Drive, Suite 610
San Antonio, TX 78229
Fax (210) 614-2462

**This information may be disclosed to and used by the following individual or organization:**

_____

Address_____Ph#_____

For the purpose of _____Fax# _____

Dates of Service: _____ to _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

____**Yes**, I consent to the release of this information. _____**No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date_____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or request a copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have question about disclosure of my health information, I may contact Rosa Tealer, Privacy Office, at 210-614-2453.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

**COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:**

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold my physician or Neurosurgical Associates of San Antonio, P.A. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

Date Request Received_____ Date Request Completed_____ # pages copied_____

Charges $_____ Cash___ Check #_____ Completed by_____