CTNC Central Texas Neurology Consultants

Diseases of the Brain, Spine, Nerves and Muscles

Edward J. Fox, M.D. Ph.D Craig H. Couch, M.D. Adam D. Horvit, M.D. Terry S. Peery, D.O. Elizabeth L. Peckham, D.O.

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Contact Phone: _____

Release Records: ☐ To: ☐ From:

Name: _____

Address: _____ City/State/Zip: _____

Office Phone: _____ Fax Number: _____

Release Records ☐ To: ☐ From:

Provider Name: **Central Texas Neurology Consultants, PA**
C.Couch, MD., E Fox, MD., A Horvit, MD., E. Peckham, DO, TS Peery, DO
16040 Park Valley Drive, Building B Suite 100 Round Rock, Texas, 78681
Fax: (512) 338-5127 Medical Records PHONE: (512) 218-1222 ext 247

Information Requested:

- ☐ All Health records
- ☐ History/Physical
- ☐ Progress Notes/Office Visits (last 3 visits)
- ☐ Labs/ Radiology/EKG/EMG/EEG Reports
- ☐ Medication List/Immunization
- ☐ Other: _____

Purpose of Requested Use of Disclosure

- ☐ Continued Medical Care
- ☐ At the request of the individual.
- ☐ Legal
- ☐ Other: _____

I understand and agree that:

I am required to make a written request for access to PHI using this form, which must be completed in order for CTNC to provide the requested information. I agree to pay CTNC for the cost of copying and mailing the said records. Such cost is calculated to be: $ _____ ($25 for 1st 20 pages (postage included); $.50 per page over 20 pages; $6 for postage and handling; and $15 for notarized copy).

Signature Authorization: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation of is otherwise permitted by law without my specific authorization or permission including disclosure to covered entities as provided by Texas Health & safety Code 181.154 (c) and/or 45 C.F.R 164.502 (a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by recipient and may no longer be protected by federal and state privacy laws.

Patient/Parent/Legal Guardian Signature: _____ Date: _____

Patient/Parent/Legal Guardian Printed Name: _____ Relationship to Patient: _____