Medical Records Release Form

FULL NAME: ________________________________ Date of Birth: __________________

Address: ____________________________________ Phone#:______________________

Social Security#:______________________________

I hereby authorize____
(**Facility or covered entity**)
To disclose medical records information with all labs and imaging and/or protected health information of the patient listed above to:

Name/Title: **Maushmi Sheth, M.D. / General Neurology and Neurophysiology**
Address: 5375 Coit Rd Suite 130, Frisco, Texas 75035
Phone #: 214-619-1910 Fax#: 214-619-1914
Purpose:____
For Treatment date(s): ____
Patient Appointment:____

_____I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV initials testing, HIV results or AIDS information.

If this authorization is for disclosure of genetic information, please describe_______________________________

Expiration: This authorization shall expire on the 180th day after it is signed, unless as provided otherwise upon the Expiration Date or event given here:
____

I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to clinic receiving the revocation. Further details may be found in the Notice of Privacy Practices.

If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.

I understand that treatment and payment are not a condition of signing this authorization. I may receive a copy of this form after I have signed it.

I have read the above and authorize the disclosure of the protected health information as stated.

____________________	____________________________________	____________________
Date	Signature of Patient/Parent/Representative	Relationship to Patient