LONE STAR NEUROLOGY

Medical Records Request Form

FULL NAME: _____ Date of Birth: _____

Address:_____

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: Lone Star Neurology Providers

Address: 5375 Coit Road, Suite 130, Frisco, TX 75035 (all records go to main office only)

Phone #: 214-619-1910 Fax#: 214-619-1914

Records Requested: _____

- ○ Imaging Results
- ○ Labwork
- ○ Consult Notes
- ○ Discharge Summary

_____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 will not expire, 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 requestor 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