Texas Parkinson and Movement Disorders

Medical Information Release Form
(HIPAA Release Form)

Patient Name: _____ DOB: _____

[ ] I authorize this release of information including the diagnosis, records; examination rendered to me and claims information. The information may be released to:

Full Name Relation Phone#
[ ] Release all Health Information
[ ] Release all Billing (including payments, collections, etc.)
[ ] Release Other (Specify):

Full Name Relation Phone#
[ ] Release all Health Information
[ ] Release all Billing (including payments, collections, etc.)
[ ] Release Other (Specify):

[ ] May NOT be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell phone: _____

If unable to reach me:

[ ] You may leave a detailed message regarding my test results.

[ ] Please leave a message for me to return your call.

Patient Signature: _____ Date: