

**ASSOCIATED NEUROLOGICAL SPECIALTIES**

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**We require your written authorization prior to sending any protected health information per HIPPA regulations.**

**Name of Patient:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I authorize the disclosure of medical records to the insurance company, and/or representative of my insurance company listed below:  
Signature: \_\_\_\_\_

I authorize the disclosure of medical records to my attorney: \_\_\_\_\_ Signature: \_\_\_\_\_

I authorize the disclosure of medical records to the following physicians and family members:

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

I understand that 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. Signature \_\_\_\_\_ Date \_\_\_\_\_

I understand that the information released is for the specific purpose stated above. Any other use of this information with the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. 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 with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_  
If I fail to specify an expiration date, event or condition this authorization will remain on file until doctor/patient relationship is terminated.

**Please initial if you authorize us to speak with/release information to the following:**

Spouse \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Daughter \_\_\_\_\_ Son \_\_\_\_\_

**CONSENT FOR TREATMENT**

I hereby authorize evaluation and treatment by Dr. Robert M Cain, Dr. Jill E. Heytens, Dr. Rosamma Joseph and Dr. George Petroff.

\_\_\_\_\_  
*Patient/Guardian Signature* *Date*

I authorize the release of my protected health information to Associated Neurological Specialties from any physician, hospital or clinic to facilitate my treatment by Robert M. Cain, M.D., Jill E. Heytens, M.D., Rosamma Joseph, M.D. and George Petroff, M.D.

I also authorize Associated Neurological Specialties to disclose my protected health information to any physician, hospital or clinic to which we refer you.

\_\_\_\_\_  
*Patient/Guardian Signature* *Date*

**Notice Concerning Complaints**  
*(Aviso Sobre Quejas)*

Complaints regarding physicians, as well as other licenses and registrants of the Texas State Board of Medical Examiner may be reported for investigation to the address below.

*(Se pueden presentar quejas acerca de medicos, asi tambien como de otras personas autorizadas y registradas pro la junta de Examinadores Medicos del Estado de Tejas (Texas State Board of Medical Examiners) para su investigacion en siguiente direccion:*

**Texas State Board of Medical Examiners**  
**Attention: Investigations**  
**1812 Centre Creek Drive Suite # 300**  
**Austin, Texas 78714-9134**  
**Phone: 1-800-201-9353**