



Authorization for Release / Request of Protected Health Information (PHI)

Prepayment Charge: There is a prepayment charge of \$10 per child for electronic records to be faxed and \$25 per child for records to be printed and picked up in office, in accordance with Texas Health and Safety Code §241.154. (Option B below)

Patient Information: Name Date of Birth Phone Number

Address: Street City State Zip Code

I authorize Austin Health Partners and Neighborly MD to release (transfer out) information to:

OR

I authorize Austin Health Partners and Neighborly MD to obtain (transfer in) information from:

Name of Provider or Facility/or Parent Name

Name of Provider or Facility/or Parent Name

Address

Address

City, State, Zip Code

City, State, Zip Code

Fax # (MUST be included along with Area Code)
Fax number must be included in order to process request

*Fax # (MUST be included along with Area Code)
Fax number must be included in order to process request

Please select the option that best suits your needs for transferring records out:

Option A (records sent electronically, \$10 charge) Option B (records printed & picked up in office, \$25 charge required)

REASON FOR DISCLOSURE (Choose only one option):

Treatment/Continued Patient Care Personal Use Attorney/Legal Insurance

Signature Authorization: I have read this form and agree to the uses and disclosures of the information as described.

Signature of Individual or Legal Authorized Representative

Date

Relationship to individual: Parent of Minor Guardian Other

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

Signature of Minor

Date

In accordance with state law and regulatory agency requirements, the health record is the property of Austin Health Partners. HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or legally authorized representative to electronically disclose that Individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function, or as may be otherwise authorized by law.

Neighborly MD Fax: (512) 808-0196



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