NORTHEAST TEXAS NEUROLOGY ASSOCIATES

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505 S. Fleishel Ave, Tyler, Texas 75702

Dear Northeast Texas Neurology Associates,

I am requesting a copy of my medical records. I understand that I can have a paper copy of my records for which I will be charged the following: $15 for the first 100 pages, $25 for 101- 500 pages, and $50 for more than 500 pages. I understand my entire medical record can be available to me through the patient portal free of charge every year.

Please check the following:

☐ I want to have my **entire medical record printed out**. If records are mailed to me, add an additional $10 for postage (mailed USPS).
- ☐ Mail my records to: _____
- ☐ I will pick up my records.

☐ I want **specific parts of my medical record printed out.** (see next page). If records are mailed to me, add an additional $10 for postage (mailed USPS first class).
- ☐ Mail my records to: _____
- ☐ I will pick up my records.

☐ I want free copy of my entire medical record available on the portal. Portal access is required to access these records. The records are available in a PDF format for you to download or print. You can have a free copy every calendar year. More frequent requests are $25 each.

Records will be released to you:

- ✓ When you have filled out the following Authorization
- ✓ Upon receipt of payment (if applicable)
- ✓ Within 10 business days

_____	_____	_____
Patient Name	DOB	Today's Date

For Internal Use:
Date Records Sent: _____ *Total Charge:* _____

Fees Collected by: _____ *on* _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FROM NETNA

Information regarding patient for whom authorization is made:
Full Name: _____
Other Name(s) Used: _____ Date of Birth: _____
Address:_____ City:_____ State:_____ Zip Code:_____
Phone: (_____)_____ Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:
Name: Northeast Texas Neurology Associates
Address: 505 S. Fleishel Ave City: TYLER State: TX Zip Code: 75702
Phone: 903-526-7055 Fax: 903-593-4303

Information regarding person or entity who can <u>receive</u> and use this information:
Name: _____
Address:_____City:_____ State:_____ Zip Code:_____
Phone: (_____)_____ Fax: (_____)_____

Specific information to be disclosed:
□ Medical Record from (insert date) _____ to (insert date) _____
□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
□ Other: _____

Include: (*Indicate by Initialing*)	This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines. In the event the health information described includes any of these types of information, and I initial the corresponding lines in the box, I specifically authorize release of such information to the person or entity indicated herein.
_____ Drug, Alcohol or Substance Abuse Records _____ Mental Health Records (Except Psychotherapy Notes) _____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results) _____ Genetic Information (Including Genetic Test Results)	

<u>The individual signing this form agrees and acknowledges as follows</u>:

(i) **<u>Voluntary Authorization</u>:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **<u>Signature Authorization</u>:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____