

Houston Aphasia Recovery Center 3701 Briarpark Dr, Suite 310 Houston, Texas 77042 Telephone – 713-781-7100

Fax - 713-781-7105

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's PRINTED NAME	Birth Date:	Date(s) of Services	Social Security #
Street Address:	City	State	Zip
Home Phone #:	Work Phone #	Cell Phone #:	Which is best contact if needed? Home Work Cell
Health Information is requested from: Address: Phone () Fax: ()			
INFORMATION SHALL BE DISCLOSED TO:			
Name of Entity to which requested records will be sent: HARC: Please fax to: 713-781-7105			
RECORDS REQUESTED ARE: (Please circle the specific requested information)			
ER Record History and Physical Consult Report(s) Operative Report(s)			
CT/MRI scan of the brain (reports only)			
Rehab Services:			
ST – Assessments - Language Cognition Swallowing Progress/Daily Notes Discharge Summary			
PT - Assessment Discharge Summary OT - Assessment Discharge Summary			
Neuropsychological - Evaluation /Testing			
Other:			
I acknowledge and hereby (circle one) consent do NOT consent that the released information may contain alcohol, drug abuse, psychiatric, psychological testing, HIV testing, HIV results or AIDS information or such disclosure shall be limited to the following specific types of information:			
By signing below, I indicate that I have read the above and authorize the staff of the disclosing facility to provide such information as requested above. I understand that this consent may be withdrawn by me at any time except to the extent that action has already been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. The disclosing facility is released			
and discharged of any and all legal liability and injuries that may arise from the release of this information to the party named above. The information that I am requesting may be sent by U.S. Mail Services and/or electronic facsimile.			
Signature of Patient/Legal Guardia	an or Representative	Date:	
If signed by other than patient, indicate relationship:			