

Austin Sleep Disorders Center
Soe Aung, M.D.
Medical Records Release Form

Chart # _____

Patient Name: _____ DOB: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below:

From: _____	To: Soe Aung, M.D.
_____	711 W. 38th Street Bldg. E-1 Austin, TX 78705
phone _____ fax _____	phone (512) 477.5337 fax (512) 682.6299

Including information (if applicable) pertaining to:

_____ Mental Health _____ Drugs/Alcohol _____ HIV/AIDS-I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

Initial: _____ Date: _____

Limitations on the information you may release subject to this release form are as follows:

The reasons or purposes for this release are as follows:

- Continued patient care Personal Use Insurance claim/Application
 Disability Determination Attorney/Legal Other: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners and/or your neuropsychologist.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Witness