Authorization for Release of Information

I hereby authorize _____ to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

Address:_____Phone number:_____ Fax number:_____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

Patient Name:_____ DOB: _____

Patient Address:_____ Phone Number:_____

Specific Date(s) of Service (if known): _____ or ____ All Dates of Service

Information to be released: (Check all that apply)

___ Complete Medical Records ___Radiology Reports & Films ___Registration Records

___Billing Records ___Visit & Encounters ___Laboratory Reports

___Specialist Consult Reports ___Emergency Room Reports ___Operative Records ___Other

Description of the purpose of the use and/or disclosure: _____

The health information described here in shall be released to North Dallas Primary Care Doctors, PLLC

7589 Preston Road Suite 600, Frisco TX 75034, Phone: (214) 705-3728; Fax: (214) 308-9464

Delivery Method: Fax

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

_____ _____

Printed name of Patient, Parent, or Legal Guardian Relationship to patient

_____

Legal Authority (Attach supporting Documentation)