North Texas Family Health

Authorization for Use/Disclosure of Protected Health Information

Monday, 12 August, 2019

I, _____ hereby authorize release of my medical records as described below to North Texas Family Health.

TYPE OF INFORMATION TO BE DISCLOSED:

_____ Entire Medical Record _____ Medical Record for Continuity of Care

_____ Financial Record _____ Laboratory Test Reports

_____ Radiology Reports _____ Treatment Summary

_____ Medication Record _____ Other: _____

In addition, I authorize that this will include health information relating to (check if applicable):

_____ Communicable diseases (including HIV and AIDS) _____ Drug/Alcohol Abuse

_____ Mental Health records

COVERED DATES OF SERVICE: This authorization includes the period of health care from:

_____ to _____ OR _____ All past, present and future periods.

EXPIRATION: This authorization will be effect, unless revoked in writing, for one (1) year from today's date or until the date written here: _____.

PATIENT INFORMATION (Please Print):

Name: _____ Date of Birth: _____

Social Security Number: _____

RELEASE MY MEDICAL RECORDS FROM:

Health Care Provider/Entity: _____

Tel: _____ Fax: _____

TO: North Texas Family Health / 980 W Van Alstyne Pkwy / Van Alstyne, TX 75495
Phone: (903)712-3627 Fax: 903-712-0060

I understand this Authorization is voluntary and I may refuse to sign it. I understand that I have the right to revoke this Authorization, in writing, at any time. I further understand that this Authorization is specific to the types of information and the dates of service listed above.

Patient or Guardian Signature: _____ Date : _____

Relationship to patient (if applicable): ___Parent or Guardian of minor ___Court appointed guardian

___Power of Attorney ___Executor of descendant's estate