AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: (please print) _____

Address: _____ City, State, Zip: _____

Date of Birth: _____ Last 4 of SSN: _____ Phone: _____

Email Address: _____

I AUTHORIZE: Dr. _____
Clinics of North Texas, LLP
501 Midwestern Parkway East
Wichita Falls, TX 76302
Ph: (940)766-8663 Fax: (940)766-8607
CNT_Medical_Records@cntllp.com

TO ☐ RELEASE TO or ☐ REQUEST FROM
Name: _____
Address: _____
City/State/Zip: _____
Ph: _____ Fax: _____

Information to be released:

_____ Entire Record (this could include drug, alcohol or substance abuse, genetic information/test results, mental health or communicable disease information such as HIV (A.I.D.S.) test results, if any)
_____ Last year of my record _____ Last 2 years of my record Other _____
_____ Lab Reports from _____ (specify timeframe)
_____ Radiology Reports from _____ (specify timeframe)
_____ Office Notes from _____ (specify timeframe)
_____ Immunization Record

The information specified above is to be released for the following purpose:

_____ My Personal Use	_____ For Insurance eligibility or claim	_____ Moving
_____ Changing Doctors	_____ Attorney	_____ Other
_____ Second Opinion/Consult	_____ Disability/Social Security/VA	

State and Federal law protect the following information. If any of this information might apply to you, please check and initial any information you would agree to release. Failure to do so could result in important information not being released.

_____ Alcohol and/or drug abuse treatment records	_____Yes	_____No	_____Initials	
_____ Psychiatric/Mental Health Records	_____Yes	_____No	_____Initials	
_____ HIV or (AIDS) testing and/or treatment records	_____Yes	_____No	_____Initials	**This especially applies**
_____ Genetic information (including genetic test results)	_____Yes	_____No	_____Initials	**to OB/GYN patients.**

I would like to receive my records in the following format:
Medical records are available electronically via flash drive (USB), paper copies, fax or e-mail **(Warning: e-mail is NOT SECURE)**.
COPY FEES: USB - $25 PAPER: $25 for the first 20 pages and $0.50 per page thereafter

I request: _____PAPER COPIES _____USB _____FAX _____EMAIL _____

I understand that I have the following rights:

- I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.
- I understand that I may revoke this authorization at any time by written request. I also understand that the revocation will not apply to information already released in response to this authorization.
- I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I understand that the signing of this authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits.
- I understand that I can ask for a copy of this authorization after signing it.

This authorization will expire sixty (60) days from the date of my signature unless otherwise specified by date, event or condition as follows:

_____

DATE: _____ SIGNATURE: _____
Patient or Legal Representative

_____
Relationship to Patient