

AUTHORIZATION FOR RELEASE OF INFORMATION

* * *					
Address:	City, State, Zip:				
Date of Birth:La	st 4 of SSN:	Phone:			
Email Address:					
I AUTHORIZE: Dr. Clinics of North Texas, LLP	TO RELEASE TO or REQUEST FROM				
501 Midwestern Parkway East	Name:				
Wichita Falls, TX 76302		Address:			
Ph: (940)766-8663 Fax: (940)766-8607 CNT_Medical_Records@cntllp.com	City/State/Zip:				
	Ph:		Fax:		
Information to be released:					
Entire Record (this could include drug, communicable disease in Last year of my record Last	nformation such as HIV	(A.I.D.S.) test results	s, if any)		
Lab Reports from					
		(specify timeframe) (specify timeframe)			
Immunization Record		(spe	ecity timetrame)		
Changing Doctors	For Insurance eligation Attorney Disability/Social information. If any of	gibility or claim Security/VA this information mi	ght apply to y		
Alcohol and/or drug abuse treatment rec	ordsY	YesNo	Initials	6 · · · · · · · · · · · · · · · · · · ·	
Psychiatric/Mental Health Records	Y	YesNo YesNo	Initials	This especially applies	
HIV or (AIDS) testing and/or treatment Genetic information (including genetic to		YesNo		to OB/GYN patients.	
	Plash drive (USB), paper co PAPER: \$25 for the first 20		page thereafter		
I understand that I have the following right:	g•				
I understand that my records are oprovided by law. I understand that I may revoke this a information already released in responsition of the information disclosured by the Health Information are hereby released from any legal	confidential and cannot authorization at any time by onse to this authorization red by this authorization red Portability and Accounta	y written request. I also may be subject to re-d bility Act of 1996. The	o understand that isclosure by the e facility, its en	t the revocation will not apply to recipient and will no longer b aployees, officers and physician	
authorized herein.I understand that the signing of this health plan benefits.	authorization is not a con	ndition for continued t			
 I understand that I can ask for a copy 				1:7: 6.11	
This authorization will expire sixty (60) days from t	he date of my signature un	less otherwise specified	d by date, event	or condition as follows:	
This authorization will expire sixty (60) days from t	he date of my signature un	less otherwise specified	d by date, event	or condition as follows:	

Relationship to Patient Revised 11/3/2021