North Texas Medical Center
AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient: _____ Phone Number: _____

Date of Birth: _____ Social Security Number: _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR:

□ Continuing Medical Care □ Military □ Social Security/Disability
□ Insurance □ Personal Use □ Other: _____
□ Legal Purposes □ School

Date(s) of Treatment: _____

INFORMATION TO BE RELEASED OR ACCESSED:

□ History & Physical □ Consultation Report □ Emergency Room Record
□ Operative Reports □ Discharge Summary □ Lab/Pathology Reports
□ Radiology Reports □ Radiology Images □ Other: _____

FORMAT REQUESTED FOR INFORMATION TO BE PROVIDED:

□ Paper □ Electronic media (requires 2 business days; only applies to data stored electronically)

METHOD OF DELIVERY:

□ Pick Up (You will be notified via a telephone call when records are ready for pick up.)
□ Mail to Address listed below

□ North Texas Medical Center □ _____ (Name of Other Facility)

May release the above information to:

_____
(Individual or Organization Name) (Phone Number)

_____
Address (Street, City, State, Zip Code)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, treatment of drug or alcohol abuse, mental illness, and/or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing Law.

This authorization will expire One Hundred and Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

_____ _____
For departmental use: MRN/AR Relationship to Patient