



# Medical Clinic of North Texas, P.A.

## Authorization to Release Medical Information to the Medical Clinic of North Texas, P.A.

I, \_\_\_\_\_, hereby authorize  
(Name of patient or legal representative)

\_\_\_\_\_  
(Name of person/entity who should release records)

\_\_\_\_\_  
(Address of person who should release records)

to release the following information by mail, fax, electronically or orally to:

**Medical Clinic of North Texas, P.A.  
Hogan Center**

Address: 800 Fifth Avenue, Suite 300  
Fort Worth, Texas 76104

Phone: (817) 334-1400 Fax: (817) 334-1410

**Information is for:**

- |  |   |
|--|---|
| <input type="checkbox"/> Dr. J. Kevin Eldridge | <input type="checkbox"/> Dr. L. Lester      |
| <input type="checkbox"/> Dr. S. Eppstein       | <input type="checkbox"/> Dr. R. Machos, Jr. |
| <input type="checkbox"/> Dr. T. Godbey         | <input type="checkbox"/> Dr. E. Nelson      |
| <input type="checkbox"/> Dr. R. Hutcheson      | <input type="checkbox"/> Dr. Y. Vargas      |
| <input type="checkbox"/> Dr. S. Johnson        | <input type="checkbox"/> Dr. J. Counts      |

From the health records of: \_\_\_\_\_  
(Name of person whose record will be disclosed) (Social Security Number)

For the purpose of: \_\_\_\_\_

**All records**

- Statements of charges or payments
- Records of all visits
- AIDS or HIV information
- History and Physical Examination
- Record of visit for a specific date(s).

- Progress Notes
- Discharge Summary
- Consultation Reports
- Hepatitis information
- Photographs, videotapes, digital, or other images

Specific dates include or are limited to: \_\_\_\_\_

- Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)
- Mental health and/or alcohol and drug abuse treatment
- Other (must be specific): \_\_\_\_\_

**This authorization is given freely with the understanding that:**

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. The Medical Clinic of North Texas, P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by this rule.
6. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Expiration Date of Authorization

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date