



**AUTHORIZATION TO RELEASE MEDICAL INFORMATION  
TO THE MEDICAL CLINIC OF NORTH TEXAS, P.A.**

**DATE TODAY:** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_ **AGE:** \_\_\_\_\_  
LAST FIRST M.I.

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:

**MCNT Arlington South**  
Address: 811 W. I-20, Suite 120  
Arlington, Texas 76017  
Phone: (817) 468-3393 Fax: (817) 468-8734

**Information is for:**  
\_\_\_\_\_  
*Physician Name*

From the health records of: \_\_\_\_\_  
(Name of person/entity who should release records)

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

- All Records
  - Statements of Charges or Payments
  - AIDS or HIV Information
  - History and Physical Examination
  - Copies of Records of Reports Provided to the Above Named (i.e. Hospital, Lab, Clinic, etc.)
  - Record of visit for a specific date(s). Specific dates include or are limited to:
- Mental Health and/or Alcohol and Drug Abuse Treatment
  - Progress Notes
  - Discharge Summary
  - Consultation Reports
  - Hepatitis Information
  - Photographs, Videotapes, Digital, or Other Images

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/Legal Representative Signature

\_\_\_\_\_  
Date

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

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

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date