



**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 Denton South OB/GYN**  
Address: 3537 S. IH 35E, Suite 200  
Denton, Texas 76210

**Dr. Asis:** Phone: (940)484-2747 Fax: (940) 382-1827

**Dr. Jarrett:** Phone: (940)535-5055 Fax: (940) 382-1324

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

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

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

Other (must be specific): \_\_\_\_\_

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

- 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.
- A photocopy or fax of this authorization is as valid as this original.
- I may revoke this authorization at any time in writing, except where information has already been released.
- 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.
- 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.
- 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