MCNT
Medical Clinic of North Texas

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 Pediatrics
Address: 811 W. I-20, Suite 214
Arlington, Texas 76017
Phone: (817) 557-5437 Fax: (817) 375-0980

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.)
- ❑ Mental Health and/or Alcohol and Drug Abuse Treatment
- ❑ Progress Notes
- ❑ Discharge Summary
- ❑ Consultation Reports
- ❑ Hepatitis Information
- ❑ Photographs, Videotapes, Digital, or Other Images
- ❑ Record of visit for a specific date(s). Specific dates include or are limited to:

_____

- ❑ 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