



Medical Clinic of North Texas, P.A. (MCNT)

Authorization to Release Medical Information

I, _____, hereby authorize the **Medical Clinic of North Texas, P.A.** to disclose the following information by:

mail fax or orally to:

Name: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ or FAX Number: _____

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

For the purpose of: _____

My authorization extends only to those data elements/documents marked below:

- | | |
|--|--|
| <input type="checkbox"/> ALL RECORDS | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Statements of charges or payments | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Records of all visits | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> AIDS or HIV information | <input type="checkbox"/> Hepatitis information |
| <input type="checkbox"/> History and Physical Examination | <input type="checkbox"/> Photographs, videotapes, digital, or other images |
| <input type="checkbox"/> Record of visit for a specific date(s). | |
| Specific dates include or are limited to: _____ | |
| <input type="checkbox"/> Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.) | |
| <input type="checkbox"/> Mental health and/or alcohol and drug abuse treatment | |
| <input type="checkbox"/> Other (must be specific): _____ | |

This authorization is given freely with the understanding that:

- Any and all records, whether written or 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, except where information has already been released. To revoke my authorization, I must submit a Revocation of Authorization to Release Medical Information Form to the clinic. The clinic will act upon my revocation within two (2) working days of receipt. This authorization is valid for a one year period from the date it is signed, or sooner if noted below.
- MCNT its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure 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.
- The patient will be provided with a copy of this authorization.

Patient's Printed Name

Date of Birth

Patient/Legal Representative Signature

Date

Relationship to Patient

Expiration Date of Authorization

Witness

Date