NORTH TEXAS ORTHOPEDICS & SPORTS MEDICINE

Authorization Form
For Release of Protected Health Information

Patient Name: ______________________ **DOB:** __________ **SS #:** __________

Address: ______________________________ **Phone #:** __________

The health information you may release subject to this authorization is as follows:

☐ **All Medical Records** ☐ **MRI / Diagnostic Films** ☐ **Pathology Reports**

☐ **X-Ray Films** ☐ **Other, Please Specify** ____________________

Release my protected health information to the following person(s) / entity:

Name: ______________________ **Phone #:** __________ **Fax #:** __________

Street: ______________________ **City:** ______________ **State:** ______ **Zip:** ______

The reasons or purposes for this release of information are as follows:

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This authorization shall expire one year from the date signed. After one year, NORTH TEXAS ORTHOPEDICS can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at NORTH TEXAS ORTHOPEDICS

ATTN: CAROLYN CALIMAN, PRIVACY OFFICER
2535 IRA E. WOODS
GRAPEVINE, TEXAS 76051
TELEPHONE 817-481-2121
FAX NO. 817-488-4493

I understand that a revocation is not effective to the extent that NORTH TEXAS ORTHOPEDICS has relied on this authorization in its actions.

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

NORTH TEXAS ORTHOPEDICS will not condition my treatment, payment, or health care operations based on whether I provide authorization for the requested use or disclosure.

______________________________ ______________________________
Signature of Patient or Personal Representative **Name of Patient or Personal Representative**

______________________________ ______________________________
Date **Description of Personal Representative's Authority**