I hereby authorize to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (“HIV”) and Acquired Immune Deficiency Syndrome (“AIDS”), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

**Address**: **Phone number:** **Fax number:**

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

Patient Name: DOB:

Patient Address: Phone Number:

Specific Date(s) of Service (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or **\_\_\_\_ All Dates of Service**

**Information to be released: (Check all that apply)**

**\_\_\_ Complete Medical Records** \_\_\_Radiology Reports & Films \_\_\_Registration Records

\_\_\_Billing Records \_\_\_Visit & Encounters \_\_\_Laboratory Reports

\_\_\_Specialist Consult Reports \_\_\_Emergency Room Reports \_\_\_Operative Records \_\_\_Other

Description of the purpose of the use and/or disclosure:

The health information described here in shall be **released to North Dallas Primary Care Doctors,** **PLLC**

**7589 Preston Road Suite 600, Frisco TX 75034**, **Phone: (214) 705-3728; Fax: (214) 308-9464**

**Delivery Method: Fax**

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient, Parent, or Legal Guardian Date

Printed name of Patient, Parent, or Legal Guardian Relationship to patient

Legal Authority (Attach supporting Documentation)