AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Please SEND medical information TO (the "<u>Receiving Provider</u>"):
___Raymon K. Aggarwal, MD
___Greta Brodsky, MD
___John C. Brooks, MD
___Dean C. Dimmitt, MD
___Jenifer Edwards, MD
___Ruby E. Kassanoff, MD
___Alison H. Sibley, MD
___Randlow Smith, Jr., MD
___Jennifer L. Wilkerson, MD

North Texas Preferred Health Partners
3417 Gaston Ave. Suite 700
Dallas, Texas 75246
Phone#: 214-823-4800; Fax#: 214-818-2784

Please REQUEST medical information FROM (the "<u>Sending Provider</u>"):

Clinic/Physician:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____

Fax:_____

I, the undersigned Patient or the Patient's legally authorized representative, hereby authorize the Sending Provider to release and/or disclose medical information as indicated below to the Receiving Provider.

Release and/or disclose records and information regarding the following Patient:

_____	_____ - _____ - _____	_____ /_____ / _____
Name of Patient	Social Security Number	Date of Birth

_____	_____	_____	_____
Address	City	State	Zip Code

_____	_____	_____
Home	Work	Cell

DURATION: *This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for ninety days from the date of signature if no date entered.*
REVOCATION: *This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the Sending Provider. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.*
REDISCLOSURE: *I understand that the Receiving Provider may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.*

PLEASE SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED: (*CD or electronic version is preferred.)*
____ Entire medical records ____ History and Physical ____ Chart Summary ____ Labs ____ Radiology ____ Pathology
____ Other (please specify) _____

YOUR INITIALS ARE REQUIRED TO RELEASE THE FOLLOWING INFORMATION:
____ Mental Health Records (excluding psychotherapy notes) ____ Drug, Alcohol, or Substance Abuse Records
____ Genetic Information (including Genetic Test Results) ____ HIV/AIDS Test Results/Treatment

REASON FOR DICLSOURE:
____ Treatment/Continuing Medical Care ____ Legal ____ Personal ____ Other (please specify) _____

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. I understand that there may be a fee for preparing and furnishing this information.

_____	_____	_____
Signature of Patient or Legally Authorized Representative	Date	Relationship to Patient (if applicable)

Printed Name of Legally Authorized Representative (if applicable): _____