

NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, P.A.

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, (patient name) _____, authorize **North Texas Infectious Diseases Consultants:**

Check ONE box

to **GET** records from: _____

Address and/or Phone number: _____

to **SEND** records to: _____

Address and/or Phone number: _____

For the following purpose: ___ patient's request, ___ continued medical care, ___ insurance, or ___ other

I specifically authorize the use or disclosure of the following health information, if such information exists:

- | | |
|-----------------------------------|---------------------|
| ___ Send my entire medical record | ___ Billing Records |
| ___ Immunization Information | ___ Office Notes |
| ___ Lab/Radiology Results | ___ Other _____ |

I understand that the specified information to be release may include, but is not limited to: history, diagnoses, treatment of HIV, AIDS, communicable diseases, mental illness and drug or alcohol abuse.

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to North Texas Infectious Diseases Consultants, P.A. (a form will be supplied to you upon request at the reception area).

Unless revoked earlier, this authorization will expire 180 days from the date of signing. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

Patient Signature

Date of Birth

Date

Return to fax number: 214-824-8679 or mail to:

**Medical records
North Texas Infectious Diseases Consultants, PA
3409 Worth St. Suite 710
Dallas, TX 75246**