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
_____Immunization Information
_____Lab/Radiology Results
____Billing Records
____ Office Notes
____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: 844-502-1196 or mail to:

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