OB/GYN
NORTH DALLAS

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## AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of Birth:_____/_____/_____
Last First MI

Authorization of Use/Disclosure of Information: I voluntarily authorize and direct my health care provider _____ to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

Recipient: Name and address of person or class of persons to whom my health care provider may disclose my information to:

_____
Name Address City State Zip

_____ _____
Phone Fax

Description of Information to release: (check all that apply)

| | | |
|---|---|---|
| __All records | ___OP Reports | ___History & Physical |
| __Emergency Room | ___Billing | ___Labs |
| __Radiology Reports | ___Consult Notes | ___Other _____ |
| __Sono Reports | ___Office Notes | _____ |

Purpose: I understand that the specific purpose of this Authorization is _____
_____
("At the request of the patient" is sufficient if the patient is initiating this authorization)

I understand that The Texas State Board of Medical Examiners allows 2 weeks for the processing of all medical records. There is a fee for patients that request medical records which must be paid prior to the records being copied and mailed. Our office follows the fee schedule put forth by the Texas State Board of Medical Examiners Board Rule 165.1. The fee is $25.00 for the first twenty pages and $0.50 for each additional page plus the cost of postage.

I understand that this 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_____.

I understand that I may refuse to sign or may revoke this authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

I further understand that to revoke my authorization, I must provide a written notice of revocation to my health care provider's Privacy Officer at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not effect any action taken by my health care provider before it received my written notice of revocation.

I may contact the Privacy Officer at: OB-GYN Associates of North Dallas, 6124 W Parker Rd, Ste 134, Plano, TX 75093 or by calling 972-981-7777.

_____ ___/___/___ _____
Signature of Patient or Patient Representative Date Signature of Witness

_____ _____ _____
Printed Name of Patient Representative Relationship to Patient Legal Authority

**Texas Health Plano**
6124 W. Parker Rd.
Suite 134
Plano, Texas 75093

972-981-7777
972-981-7750 Fax

www.obgynnorthdallas.com