

AUTHORIZATION TO RELEASE MEDICAL RECORDS

THERE IS A \$25 CHARGE TO RECEIVE A COPY OF YOUR RECORDS COPIES FOR OTHER DOCTORS ARE FREE OF CHARGE

I _____, hereby authorize

NORTH COUNTRY FAMILY PRACTICE, 1050 E. Hwy 114, Suite 100, Southlake, Texas 76092

To disclose the following specific medical information by ___mail or ___fax TO:

INFO OF OFFICE THAT WILL BE RECEIVING YOUR RECORDS

Name: _____
Address: _____
City, St., Zip: _____
Office Telephone: _____ Fax: _____

From the Health Records of:

PATIENT'S INFORMATION

Name: _____ DOB _____ Last 4 of SS# _____
Address: _____
City, St., Zip: _____

For the purpose of: _____

My authorization extends only to those data elements/documents initialed below:

- | | |
|--|---|
| <input type="checkbox"/> Statements of charges or payments | <input type="checkbox"/> Records of visits (all visits) |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Photographs, videotapes, digital or other images |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> History and Physical Examination |
| <input type="checkbox"/> Consultation Reports | |
| <input type="checkbox"/> Record of visit for specific date or dates specific dates include or are limited to: _____ | |
| <input type="checkbox"/> Copies of records or reports provided to the above named (i.e.hospital, lab, clinic, etc) | |
| <input type="checkbox"/> All of the above | |
| <input type="checkbox"/> Other (Must be specific) _____ Mental Health and/or alcohol and drug abuse treatment <input type="checkbox"/> Hepatitis information | |

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. North Country Family Practice, P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ Patient's Name Printed	_____ Date
_____ Patient's signature (or guardian, if a minor)	_____ Expiration date (if other than one year from date above)
_____ Social Security Number (for identification purposes only)	_____ Date of Birth
_____ Patient's Personal Representative	_____ Date

Patient's Personal Representative's Authorization to Act

Witness