North Country Family Practice
1050 E. Hwy 114, Suite 100, Southlake, Texas 76092
817/329-8364 fax 817/329-1285

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I _____, hereby authorize

INFO OF OFFICE THAT WILL BE RELEASING YOUR RECORDS
Name:_____
Address: _____
City, St., Zip: _____
Office Telephone:_____ Fax:_____

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

NORTH COUNTRY FAMILY PRACTICE
1050 E. Hwy 114, Suite 100, Southlake, Texas 76092 * fax 817/329-1285

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:

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