NORTH TEXAS
OB-GYN ASSOCIATES

Patient Name: _____ Patient DOB:_____

## AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF HEALTH INFORMATION

I authorize the disclosure of my personal health information (PHI) to the persons/entities as described below. I understand this authorization is voluntary and made to confirm my directions. I understand that once the information is disclosed, it may be re-disclosed and no longer protected by federal privacy regulations unless information is being disclosed to another entity that falls under HIPAA regulations. I hereby give permission to North Texas Ob-Gyn Associates to disclose my PHI in the manner described herein.

Okay to leave a detailed message on _____ Home _____ Work _____ Cell PH#_____

| **PHI MAY BE DISCLOSED TO:** | |
|---|---|
| Person: | Phone #: |
| Address: | |
| Person: | Phone #: |
| Address: | |
| Person: | Phone #: |
| Address: | |
| Please list your Primary Care Physician (PCP) and/or any other doctor you would like to have information released to: | |
| Facility/Doctor: | Phone #: |
| Address: | Fax #: |
| Facility/Doctor: | Phone #: |
| Address: | Fax #: |
| Facility/Doctor: | Phone #: |
| Address: | Fax #: |

Right to Revoke: I understand that I may revoke this authorization in writing at any time. I understand my revocation will NOT affect any disclosures that occurred before North Texas Ob-Gyn Associates received and processed a written notice of revocation. I understand that this authorization will expire one year from the date of signature below. To revoke this authorization, I understand that I must send a written request to North Texas Ob-Gyn Associates, ATTN: Privacy Officer, 328 W. Main, Lewisville, TX 75057.

**ACKNOWLEDGEMENT**
Please sign and date:
I have had full opportunity to read and consider the contents of this authorization and I confirm that the contents are consistent with my direction to North Texas Ob-Gyn Associates to release nonpublic PHI.

_____ _____

Signature of Patient or Legal Representative Date