AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Patient DOB: _____

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.

In order to communicate with you in the best way possible for reasons such as but, not limited to: lab results, follow up care, insurance information, estimated cost for upcoming appointments, balances owed, we need to know your preference. You may check all that apply but, please note, we will need to be able to leave brief but detailed information. _____ Patient Portal _____ Email _____ Cell Phone _____ Home Phone

PHI MAY BE DISCLOSED TO:	
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 #:

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 two years 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.

PRIVACY (HIPAA): Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy from our website or by contacting our office.
You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance of your prior Consent. North Texas Ob-Gyn Associates provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
The patient understands that:

- PHI may be disclosed or used for treatment, payment or health care operations.
- North Texas Ob-Gyn Associates has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- North Texas Ob-Gyn Associates reserves the right to change the Notice of Privacy Practices.
- The patient has the right to request restrictions to the uses of their information but North Texas Ob-Gyn Associates does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and full disclosures will then cease.
- North Texas Ob-Gyn Associates may condition receipt of treatment upon execution of this Consent.

ACKNOWLEDGEMENT
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