NORTH TEXAS FAMILY MEDICINE

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Patient Authorization for Release of Protected Health Information to Third Parties

By signing this authorization, I authorize North Texas Family Medicine to disclose certain protected health information (PHI) about me to or for the party listed below.

This authorization permits North Texas Family Medicine to use or disclose to:

Name of third party: _____

Relationship to patient: _____

The following individually identifiable health information (IIHI):

any and all information

date of service_____to_____

information related to_____

This authorization will expire on: _____

indefinite

May we leave a message regarding test results etc on: cell phone voicemail

home voicemail

#_____ only

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected be the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent the North Texas Family Medicine has acted in reliance upon this authorization. My written revocation must be submitted to North Texas Family Medicine Privacy Officer at 1340 N HWY 377, Ste 110, Pilot Point, Texas 76258.

_____

Patient Printed Name

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Legal Guardian Name (if applicable) Relationship to Patient

Patient/Guardian to be provided with a signed copy of authorization