NTOS
NORTH TEXAS
ORTHOPAEDIC & SPINE

Authorization for Release of Patient Information

Patient Name:_____ Date of Birth: _____

Social Security #: xxx-_____ Maiden Name: _____

I request and authorize: _____
(Physician/Clinic or Practice to release records)

To release the medical records for the above-mentioned patient to:

Name of Recipient: _____

Address: _____

Phone and fax #: _____

Reason for Release: _____

This request and authorization is for: (initial appropriate line)

_____ Healthcare Information relating to the following treatment condition or dates of service:

_____

_____ All healthcare information

_____ I understand I have the right to revoke this authorization by providing a written request to do so to the above-named physician. I understand that the revocation will not apply to information that has already been released.

There is a fee for all records released to an individual. The fee is waived as a courtesy if records are released to a provider's office or hospital.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Relationship or status if signed by anyone other than the patient (parent, legal guardian, representative

Unless otherwise revoked this authorization will expire six months from the date signed. I understand that the authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by confidentiality rules.

North Texas Orthopaedic & Spine
4090 Mapleshade Ln, Ste 100, Plano, TX 75093
Ph: 214-592-9955 Fax: 214-592-9935