7777 Forest Lane Suite B446
Dallas, Texas 75230
Phone 972-566-8822 Fax 972-566-8861

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO NORTH TEXAS DIALYSIS ACCESS CLINIC

FACILITY/DOCTOR RECORDS REQUESTED FROM: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY: _____

I hereby authorize the release of any protected health information from my medical record which North Texas Dialysis Access Clinic deems necessary for my care. I understand the information disclosed may contain information on testing, diagnosis, and/or treatment for HIV, AIDS, sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use. I understand that this authorization is voluntary and I may refuse to sign this authorization. I understand that my receiving treatment with North Texas Dialysis Access Clinic will not be affected by my refusal to sign this form.

Information to be released:

_____History/Physical	_____Progress Notes	_____Discharge Summary
_____Consultation	_____Operative Report	_____Lab Reports
_____Chest X-rays	_____Radiology	_____Office Notes
_____Special Tests/Therapy	Other(Specify)_____	

Specific Date of Service:
_____
*Note: If no date of service is indicated, the request is for the most current information available.

This authorization does not expire. It may be revoked, but not retroactively on records already released in good faith.

_____ _____
Signature Date

_____ _____
Witness Signature Date