



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.

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