

Date Request Completed/Faxed:  
 Total Pages Released:  
 Request Completed By:

I hereby authorize the Hospital marked below to release records to the recipient designated below.

**DFW Sites:**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Medical City Alliance  | <input type="checkbox"/> Medical City Denton     | <input type="checkbox"/> Medical City Green Oaks  | <input type="checkbox"/> Medical City McKinney/Wysong |
| <input type="checkbox"/> Medical City Arlington | <input type="checkbox"/> Medical City Fort Worth | <input type="checkbox"/> Medical City Las Colinas | <input type="checkbox"/> Medical City North Hills     |
| <input type="checkbox"/> Medical City Dallas    | <input type="checkbox"/> Medical City Frisco     | <input type="checkbox"/> Medical City Lewisville  | <input type="checkbox"/> Medical City Plano           |

**Section A: This section must be completed for all Authorizations (Texas)**

PATIENT INFORMATION		RECIPIENT INFORMATION		
Patient's Name:		Recipient's Name:		
Patient's Date of Birth:		Recipient's Phone:		
Patient's Phone Number:		Recipient's Fax #: <i>(FAX only to Physician Office/Medical facility)</i>		
Patient's Last Four Digits SSN (optional):		Recipient's Address:		
		City:	State:	Zip:

Request Delivery (If left blank, a paper copy will be provided):  Paper Copy  Electronic Media, if available (e.g., USB drive, CD/DVD, eDelivery)  
 Encrypted Email  Unencrypted Email

**NOTE:** In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above please print legibly): \_\_\_\_\_

Unless a shorter time period is specified, this authorization will expire 180 days after the date it is signed: (Fill in the Date or the Event but not both.)

Date: \_\_\_\_\_ Event: \_\_\_\_\_

Purpose of disclosure:

**Description of information to be used or disclosed**

Is this request for psychotherapy notes?  Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.  No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> History & Physical		<input type="checkbox"/> Operative Reports		<input type="checkbox"/> Discharge Instructions	
<input type="checkbox"/> Consultation Reports		<input type="checkbox"/> EEG/EKG/Stress Test		<input type="checkbox"/> Face Sheet	
<input type="checkbox"/> Lab/Pathology Reports		<input type="checkbox"/> Radiology Reports		<input type="checkbox"/> Itemized Bill/UB-04	
<input type="checkbox"/> Medication sheets		<input type="checkbox"/> Radiology Images		<input type="checkbox"/> Complete Record	
<input type="checkbox"/> Discharge/Death Summary		<input type="checkbox"/> Emergency Room Record		<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. \_\_\_\_\_ (Initial)

If this authorization is for disclosure of genetic information, please describe: \_\_\_\_\_

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
- I get a copy of this form after I sign it.

**Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI?**  Yes  No

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information?  Yes  No

If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration?  Yes  No

**Section C: Signatures**

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:



10030 N. MacArthur Blvd., Irving, TX 75063  
 (888) 749-7952  
 Fax: (469) 484-2006

PATIENT IDENTIFICATION

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)**



WHITE - Medical Record

YELLOW - Patient

DPC00224 (Rev. 03/17)