



ORTHOPAEDIC  
ASSOCIATES  
OF NORTH TEXAS

**AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION  
(MEDICAL RECORDS)**

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I request and authorize Orthopaedic Associates of North Texas to release copies of my Medical Records to:

\_\_\_\_\_  
Name of person or Organization to receive records

\_\_\_\_\_  
Address, City, State, Zip Code

This authorization applies to the following records/reports:

ALL Records       MMI Rating       Consults       Clinical Notes  
 Pathology       EMG Studies       Op-Reports       X-rays  
 History & Physical       Medications

This authorization shall become effective immediately and shall remain in effect for (1) one year from the initiated date. I understand that requesters may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law. I further understand that I have the right to receive a copy of this authorization upon request and that I may revoke this authorization by written request at any time. Federal rule prohibits any further disclosure of this information unless disclosure is expressly permitted by written consent of the person to whom it pertains.

Upon receipt of payment, records will available for pick-up or mailed in 48 hours. A valid driver's license or picture ID is required when picking up records.

Records to be mailed?  Yes  No

Picked-Up?  Yes  No      Which location?  Allen  McKinney

\_\_\_\_\_  
Signature of Responsible Party      Date

<b>FOR OANT USE ONLY:</b>	
Date Records Mailed / Picked-Up _____	Fees Paid _____
OANT Employee: _____	