NORTHEAST TARRANT INTERNAL MEDICINE ASSOCIATES, L.L.P.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

RELEASE TO: _____

_____

_____

RELEASE FROM: Northeast Tarrant Internal Medicine Associates
469 Westpark Way
Euless, Texas 76040

Ph: 817-358-5500
Fax: 817-283-1181

I, the undersigned, authorize the release of medical records from the medical record of:

PATIENT:

SOCIAL SECURITY:

DATE OF BIRTH:

From Date_____ To Date _____

Reason for release:_____

Information to be released:

_____ History & Physical _____ Office Visits _____Pap Smears/Lab

_____ Mammograms/Sonos _____ Discharge Summaries _____ Other-Specify _____

_____ X-ray/EKG/Bone Dexa _____ Operative Reports _____All

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems. And this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted disease and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith. This authorization expires ninety (90) days from the date of this signature.

_____ _____

Signature of patient or Legal Representative (please specify relationship to patient) Date