17051 North Dallas Parkway, Suite 150
Addison, TX 75001

(972) 733-3090 office, (972) 733-4565 fax
www.AddisonInternalMedicine.com

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

Patient Name:	**Date of Birth:**	**Social Security Number *(optional)*:**

Provider's Name:	**Recipient's Name:**
☐ J. Shaun Murphy, MD ☐ Tri T. Nguyen, MD ☐ Quynh Ton-That, MD	☐ J. Shaun Murphy, MD ☐ Tri T. Nguyen, MD ☐ Quynh Ton-That, MD
Provider's Address: **Dallas Medical Specialists** **7777 Forest Lane, Suite C-300** **Dallas, TX 75230** **(972) 566-6000 office, (972) 566-6966 fax**	**Recipient's Address:** **Addison Internal Medicine, PA** **17051 North Dallas Parkway, Suite 150** **Addison, TX 75001** **(972) 733-3090 office, (972) 733-4565 fax**

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: **Event:**

Unless a shorter time period is specified, this authorization will expire 180 days after the date it is signed.

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):***
☐ All PHI in medical record ☐ Admission/Registration records ☐ History and Physical ☐ Physician's orders ☐ Progress notes ☐ Clinical/Laboratory tests ☐ Medication records		☐ Operative Records ☐ Radiology reports ☐ Special test/therapy ☐ Consultation reports ☐ Nurse's notes ☐ Transfer forms ☐ ER Information		☐ Labor/Delivery summary ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Billing records ☐ UB-92: ☐ Other: ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain communicable diseases such as HIV and AIDS, mental illness (except for psychotherapy notes), alcohol or chemical dependency, laboratory test results, medical history, treatment, or any other such related information. _______________ (Initial)

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

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. 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.
4. 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 re-disclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?

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

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

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:**