

**OB-GYN ASSOCIATES OF NORTH DALLAS**

OBSTETRICS, GYNECOLOGY & INFERTILITY

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**AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI

Authorization of Use/Disclosure of Information: I voluntarily authorize and direct my health care provider \_\_\_\_\_ to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

Recipient: Name and address of person or class of persons to whom my health care provider may disclose my information to: \_\_\_\_\_

Description of Information to release:  
(check all that apply)

- |   |   |   |                                |
|---|---|---|--------------------------------|
| <input type="checkbox"/> Emergency Room     | <input type="checkbox"/> Radiology Reports    | <input type="checkbox"/> Admission/Registration | <input type="checkbox"/> Other |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Laboratory Reports     | _____                          |
| <input type="checkbox"/> Nurse Notes        | <input type="checkbox"/> Physician Orders     | <input type="checkbox"/> Billing Records        | _____                          |
| <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Operative Reports    | <input type="checkbox"/> Discharge Summary      | _____                          |
| <input type="checkbox"/> Sono Report        |   |   |                                |

Purpose: I understand that the specific purpose of this Authorization is \_\_\_\_\_

("At the request of the patient" is sufficient if the patient is initiating this authorization)

I understand that this will expire, by law, 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until \_\_\_\_\_.

I understand that I may refuse to sign or may revoke this authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

I further understand that to revoke my authorization, I must provide a written notice of revocation to my health care provider's Privacy Officer at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not effect any action taken by my health care provider before it received my written notice of revocation.

I may contact the Privacy Officer at: OB-GYN Associates of North Dallas, 6124 W Parker Rd, Ste 134, Plano, TX 75093 or by calling 972-981-7777.

\_\_\_\_\_  
Signature of Patient or Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name of Patient Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Legal Authority