North Central Urology P.A.

Dennis L. Ortiz, D.O.

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REQUEST FOR PROTECTED HEALTH INFORMATION TO BE RELEASED TO DENNIS L. ORTIZ, D.O.

DATE: _____

Name:_____ **DOB:**_____ **SS#:**_____

From: _____

_____

_____

To: **Dennis L. Ortiz, D.O.**
Please FAX records to: (817) 283-2175

Records to Release:

___ **All** ___ **Labs** ___ **Radiology** ___**Progress Notes** ___ **Other**_____

_____ _____
Signature of patient or personal representative **Date**

_____
Name of patient or personal representative

_____
Description of personal representative's authority

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification by mail or fax to Dennis L. Ortiz, D.O., attn: privacy officer, at 4218 Gateway Dr., Suite 100, Colleyville, TX 76034. I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage or as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.