North Central Urology P.A.

Dennis L. Ortiz, D.O.

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AUTHORIZATION FOR DENNIS L. ORTIZ, D.O. TO RELEASE PROTECTED HEALTH INFORMATION

DATE: _____

I, _____ do hereby authorize Dennis L. Ortiz, D.O., to disclose my Protected Health Information (PHI) to physician/entity listed below:

_____

_____

_____

Purpose for Release:

___ Continuity of Care ___ Disability Application/FMLA ___ Other: _____

Records to Release:

___ All ___ Labs ___ Radiology ___Progress Notes ___ Other_____

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

_____
Name of patient or personal representative

_____
Date of Birth

_____
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.