Client Name: {First, Middle, Last Name} _____ **AthenaOne ID:** _____

Address: {Address, City, State, Zip}_____ **Date of Birth:** _____

Phone Numbers(s):{HOME PHONE}_____ {PATIENTMOBILEPHONE}_____

Authorization for Release of Information

I hereby authorize Prism Health North Texas (PHNTX) to request and/or release the information specified below from the medical record(s) of the above named client in the following ways: verbally, in writing. and/or through secure (encrypted) email.
The information shall be requested from and/or released to:

FROM:		TO:	
	Name of Person/Organization		Name of Person/Organization
	Address, City, State, Zip code		Address, City, State, Zip code
	Phone Number / Fax Number		Phone Number / Fax Number

Client information is needed for *(Please select only one):*

☐ Continuing Medical Care ☐ Legal Purposes ☐ Insurance/Billing/Claims
☐ Social Security/Disability ☐ Other(explain),

Information to be released or accessed (Please check all that apply):

☐ Progress Notes Only
☐ History and Physical Exam
☐ Diagnostic Imaging Reports
☐ Diagnostic Test Results
☐ Discharge Summary
☐ Most Recent Laboratory Tests
☐ Letter of HIV Diagnosis
☐ Medication/Prescription Information
☐ Common Intake Form (CIF)
☐ Proof of income, Residency, Picture ID
☐ Psychosocial History
☐ Alcohol/Drug Use History & Treatment
☐ Criminal Justice History/Probation/Parole
☐ Psychiatric History & Treatment
☐ Hospitalization Records from dates: _____
☐ Emergency Room Visit on: _____
☐ Clinic Visits from dates: _____
☐ Other:

In addition, I authorize that this will include health information relating to (check if applicable):

☐ HIV/AIDS infection ☐ Drug/Alcohol abuse ☐ Genetic Testing

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that PHNTX has relied on this authorization. The written revocation should be addressed to my assigned Prism Health North Texas staff member, at 3900 Junius Street, Dallas, Texas 75246 (fax# 214-303-1032). Unless otherwise revoked, I understand that this authorization expires in three hundred sixty-five (365) days from the date of signature. A copy of this authorization is considered as valid as the original.

I understand that if the recipient authorized to receive the health information is not a covered entity (e.g. non-health care provider) the released information may be redisclosed and may no longer be protected by federal and state privacy regulations. I understand that PHNTX will not condition treatment, payment, enrollment or eligibility for benefits based on completion of this form. I understand I may be charged a fee for copies of medical records.

_____ Signature of Client or Legal Representative	_____ Date
_____ Printed Name of Client's Representative(if applicable)	Relationship to Client (if applicable) ☐ Court appointed guardian ☐ Executor or administrator of decedent's estate ☐ Power of Attorney