Date Request Completed/Faxed:
Total Pages Released:
Request Completed By:

I hereby authorize the Hospital marked below to release records to the recipient designated below.

DFW Sites:

☐ Medical City Alliance ☐ Medical City Arlington ☐ Medical City Dallas ☐ Medical City Denton ☐ Medical City Fort Worth ☐ Medical City Frisco ☐ Medical City Green Oaks ☐ Medical City Heart and Spine ☐ Medical City Las Colinas ☐ Medical City Lewisville ☐ Medical City McKinney/Wysong ☐ Medical City North Hills ☐ Medical City Plano ☐ Medical City Weatherford

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

PATIENT INFORMATION	DELIVERY INFORMATION
Patient's Name:	**Name:**
Patient's Date of Birth:	**Phone:**
Patient's Phone Number:	**Fax #:** ***(FAX only to Physician Office/Medical facility)***
Patient's Last Four Digits SSN *(optional)*:	**Address:**
	City: **State:** **Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.,* CD/DVD, eDelivery)**
☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.,* paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above please print legibly):_____

This consent shall become invalid and expire 180 days from the date of signature, unless otherwise stated:

Expiration Date: **or** **Expiration Event:**

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):***
☐ History & Physical		☐ Operative Reports		☐ Discharge Instructions	
☐ Consultation Reports		☐ EEG/EKG/Stress Test		☐ Face Sheet	
☐ Lab/Pathology Reports		☐ Radiology Reports		☐ Complete Record	
☐ Medication sheets		☐ Radiology Images		☐ Other:	
☐ Discharge/Death Summary		☐ Emergency Room Record			

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, **HIV** testing, **HIV** results or **AIDS** 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 redisclosed.
5. I understand that I may see and obtain a copy of 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 and/or does it involve the sale of PHI?** ☐ Yes ☐ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

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:**

PARALLON

10030 N. MacArthur Blvd., Irving, TX 75063
(888) 749-7952
Fax: (469) 484-2006

PATIENT IDENTIFICATION

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

* R O I *

WHITE - Medical Record **YELLOW -** Patient