



Patient Authorization to Release Personal Health Information

The intent of this authorization is to grant permission to disclose my personal health information, concerning the medical findings and treatment, to the authorized person indicated below. This authorization will allow CNT to release either verbally or in written form, information about my general medical condition including my diagnosis:

I authorize \_\_\_\_\_, to discuss or receive  
(Print name and relationship)  
my medical information.

This  includes  does not include  
information pertaining to HIV, AIDS or any Psychotherapy notes.

**You must select one of the following:**

This authorization is valid for **ALL** physicians at Clinics of North Texas, LLP.

This authorization is valid only for those physician I have indicated below:

\_\_\_\_\_

I understand this authorization may be revoked ***in writing*** at any time,, except to the extent that action has already been taken in reliance on this authorization.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date \_\_\_\_\_