AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please fill this page out if you would like to release your healthcare information to Dignity Primary Care

Patient Name:_____ **Date of Birth:**_____/_____/_____

Social Security Number: _____

I request and authorize _____**to release healthcare information of the patient named above to:**

Dignity Primary Care
328 W Main St Suite200
Lewisville TX 75057
Phone: (972) 537-5813 Fax: (866) 779-1998

This request and authorization applies to:

Healthcare information relating to the following treatment, conditions or dates:

_____

☐ All healthcare information relating to the above OR

- ☒ Records only
- ☒ Lab results and X-ray/Radiology Reports
- ☐ Consultant Notes
- ☐ Other: _____

I authorize the release of any records regarding drug, alcohol, or mental health treatment to Dignity Primary Care. ☐ Yes ☐ No

I understand that I have the right to withdraw this consent at any time upon written notice to the Dignity Primary Care Director.

_____ _____/_____/_____
Patient Signature **Date**

_____ _____/_____/_____
Parent/Guardian Signature **Date**

This Authorization Expires 180 Days After It Is Signed