North Texas Family Health
Release of Protected Health Information

2021 revised

For Release of Protected Health Information (PHI)

General Information As a patient of North Texas Family Health, when you seek medical advice or receive medical care information (past, present, and future) and personal information such as your name, address and social security number. This information will be used for the treatment of your medical condition(s), obtaining payment from your insurance company and for Healthcare Operations within North Texas Family Health.

Notice of Privacy Practices

For a description of how your Protected Health Information (PHI) may be used and disclosed, please review North Texas Family Health's "Notice of Privacy Practices" prior to signing this consent. A copy of the notice is available on our website (http://notexfh.com), on the North Texas Family Health's "Patient Portal", or at the reception desk. You may keep a copy for your records. North Texas Family Health reserves the right to change the notice and will notify all patients of such changes prior to the effective date.

Patient Rights

You have the right to restrict the uses and disclosures of your PHI for the purpose of your treatment, payment for your services and the healthcare operations of North Texas Family Health, however we are not required to agree to requested restrictions but we are bound by any restrictions agreed upon.

Permission to release Your Protected health Care Information to Family Members or Others

Please mark whether or not you choose to authorize us to release medical and/or insurance information to family or others**:**

Any person who you authorize to receive you Protected Health Information from North Texas Family Health are to be listed below. This form can be edited or altered by you anytime. However, any person not listed below cannot receive any medical, billing, insurance, or private information from our records without your expressed permission in writing.

Include First Name, Last Name, Relationship to you (parent, child, spouse, etc.), and their Date of Birth in the answer box. ***If multiple, please separate them with a number (1, 2, 3, etc.).***

I give permission for the following to receive my PHI

Name: ____ Relationship: ________________________________.

Name: ____ Relationship: ________________________________.

Name: ____ Relationship: ________________________________.

Name: ____ Relationship: ________________________________.

Name: ____ Relationship: ________________________________.

Name: ____ Relationship: ________________________________.

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North Texas Family Health has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.
Your signature below acknowledges: You have read and understand this consent.

1. You agree to authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician seeing you.
2. You agree to have the PHI used and disclosed by North Texas Family Health for the purpose of your treatment, to secure payment for your treatment and for North Texas Family Health healthcare operations.
3. Prior to signing this consent, you were given the opportunity to review North Texas Family Health's "Notice of Privacy Practices."
4. You are permitting the release of your PHI to the persons noted above.
5. You are aware that you may now or at any time request restrictions to the use and disclosure of your PHI

Name: ____ Today's Date: ________________

Signature: ____