Morning Light Family Medicine, P.A.

7000 Parkwood Blvd, Ste B200
Frisco, TX 75034

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Authorization To Release Healthcare Information

Patient's name: _____ Date of birth: _____

Previous name (if applicable): _____

I request and authorize _____ phone ( ) _____

to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

This request and authorization applies to:

- o Healthcare information relating to the following treatment, condition, or dates:
  _____
  _____
- o All healthcare information
- o Other _____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: _____

I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.

c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.

Patient Signature _____ date signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED