AUTHORIZATION TO RELEASE MEDICAL INFORMATION FROM USMD|MCNT

I, _____, hereby authorize
(Name of patient or legal representative)

MCNT (an affiliate of USMD Affiliated Services), to disclose the following information by ☒ mail ☒ fax ☒ orally to:

Name: Dr. Prasanthi Tondapu
(Name of person/entity who should receive records)

Address: 3848 North Tarrant Parkway, Suite 120
(Address of person/entity who should receive records)

City, State, Zip Code: Fort Worth, TX 76244

Phone Number: 469-930-4655 Fax Number: 877-776-3240

From the health records of: _____
(Name of person whose record will be disclosed)

Name of Patient: _____ D.O.B._____ Age:____
LAST FIRST M.I.

For the purpose of:_____

My authorization extends only to those data elements/documents marked below:

- ☐ All Health Information
- ☐ Statements of Charges or Payments
- ☐ AIDS or HIV Information *Initials* _____
- ☐ History and Physical Examination
- ☐ Copies of Records of Reports Provided to the Above Named (i.e. Hospital, Lab, Clinic, etc.)
- ☐ Mental Health and/or Alcohol & Drug Abuse Treatment *Initials* _____
- ☐ Progress Notes
- ☐ Substance Abuse Records *Initials* _____
- ☐ Genetic Information (inc. genetic test results) *Initials* _____
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Hepatitis Information
- ☐ Photographs, Videotapes, Digital, or Other Images
- ☐ Record of visit for a specific date(s). Specific dates include or are limited to:

_____

- ☐ Other (must be specific):

_____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. MCNT, an affiliate of USMD affiliated service, its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
6. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Relationship to Patient Expiration Date of Authorization
unless otherwise noted, authorization expires 1 year from date of signature above

_____ _____
Witness Signature Date

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

_____ _____
Signature of Minor Individual Date