# NORTH DALLAS INTERNAL MEDICINE ASSOCIATION
# AUTHORIZATON FOR RELEASE OF INFORMATION

***Dr. Jeb S. Miers***
***8210 Walnut Hill Lane Ste812***
***Dallas, Tx 75231***
***Phone 214-696-1118 Fax 214-696-4447***

*I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.*

*Patient name:* ____________________________________

*DOB:*___________________________________________

*Social Security Number:* ______________________________________

*Persons/organizations providing the information:* _____________________

*Persons/organizations receiving the information:* ______________________

*Specific description of information (includes dates):* ____________________

*What is the purpose of the use or disclosure?* __________________________________

*I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.*
*I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.*

*Signature of patient or patient's representative:* ____________________

*Date:* ________________
*Printed name of patient's representative:* _________________
*Relationship to the patient:* __________________

- *You may refuse to sign this authorization*
- *You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.*