Primary Office and Corespondence:

4001 W. 15th Str., Ste 425 B, Plano, TX 75093

NTSOA Satellite Offices:

- 5680 Frisco Square Blvd., Ste. 2500, Frisco, TX 75034
- 4510 Medical Center Dr., Ste. 302, McKinney, TX 75069
- 6750 N MacArthur Blvd., Ste. 257, Las Colinas, TX 75039
- 3537 S. I35E, Ste 220, Denton, TX 76210
-

Phone (972) 696-0030
Fax (972) 696-0037

Physicians:

- David L. Smith, M.D., FACS
- Thomas E. Le Voyer, M.D., FACS
- M. Umar Butt, M.D.
- Fred S. Lee, M.D.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: « ______________________

I request and authorize North Texas Surgical Oncology Associates, Dr. Smith, Dr. Le Voyer, Dr Butt and/or Dr. Lee to release healthcare information of the patient named above to:

Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip Code: __________

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other ______________________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates? ______________________

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☐ All healthcare information

☐ Other: ______________________

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _________ Day __________ Year _________

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.