



Parkland

NATIONAL PROVIDER IDENTIFIER (NPI) RELEASE/ACKNOWLEDGEMENT FORM

I hereby authorize the following individuals including, without limitation, Parkland Health & Hospital System, its representatives, employees and/or designated agent(s) to obtain an NPI on my behalf. This is to include authorization to release of NPI information to health plans, clearinghouses, insurance providers and any entity that may require it for use in electronic standard transactions for billing purposes as outlined in the Federal Register (The Health Insurance Portability and Accountability Act of 1996 (HIPAA).45 CFR § 162.410-162.414 and 162.610

I acknowledge that I have read and understand the foregoing Release. I understand and agree that a facsimile or photocopy of this Release shall be as effective as the original.

Training Program Name

Full "Legal" Name (Please print or type – First, Last, Middle and Suffix)

Social Security Number

Medical Degree

Place of Birth

Date of Birth

Gender: Male Female

Texas Medical License Number (if applicable)

Provider Signature

Date

NOTE: If you currently hold an NPI number, please provide number: _____