RUCKER
A Limestone Medical Center Clinic

Rettig Family Health Care
A Limestone Medical Center Clinic

LMC Limestone Medical Center

KCHC
A Limestone Medical Center Clinic

FMC Family Medicine Center

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

Authorization for Release of Medical Records

Patient _____ **DOB** _____

Address _____ **City, State** _____ **Zip**_____

Phone: _____ **Email:** _____

I, the patient, give Limestone Medical Center or _____ **my permission to release ANY/ALL medical information (including diagnostic information, lab results and radiology reports) to the person/persons listed below.**

I may revoke this authorization at any time, except where information has already been released. This authorization is valid for one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.

I understand that if I do not list anyone below, no information will be given to anyone other than myself.

Information can be released to:

Name _____ **Relationship** _____ **Phone** _____

Name _____ **Relationship** _____ **Phone** _____

Name _____ **Relationship** _____ **Phone** _____

Reason for release □ Continuation of care □ Request of patient □ Billing □ other:

Records copy delivery: □ Paper □ Mail □ PDF via Email □ other _____

Drug and/or Alcohol abuse, and/or Psychiatric, and/or HIV/AIDS records release:
I understand and agree that the information requested may contain reference(s) to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, HIV/AIDS, Hepatitis B or C testing, and/or other sensitive information.

□ Demographic	□ Physician's Orders	□ Emergency Room Record
□ History/Physical Exam	□ Laboratory Reports	□ Radiology Reports / CD
□ Discharge Summary	□ EKG/CT scan/MRI/US	□ Nurses' Notes
□ Pathology Report	□ Physician's Notes	□ Entire Chart
□ Billing Records	□ Immunization	□ Other

It is understood that the information released is for specific purposes and may not be provided in whole or in part to any other person, agency, facility or organization except to the entity stated above. This consent will expire after twelve (12) months after the date of the signature below.

By typing my name below, I certify that this information can be used for the purpose of processing my Authorization for Release of Information request. I consider this as my electronic signature for this request.

_____ _____
Printed name of patient/or guardian of patient **Relationship to patient or self**

_____ _____
Signature of patient/guardian **Date signed**