LMC HOUSE CALL PROGRAM
204 W Trinity St
Groesbeck, TX 76642
Tel: 254-729-4303 Fax: 254-276-9331

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

Please read before signing: *DO NOT SIGN BLANK FORM*

☐ Patient Name: _____ DOB: _____ SS# (LAST 4) _____

PURPOSE OF DISCLOSURE: (CHECK ONE):

☐ Continuity of Care / Care Coordination

I authorize and direct the release of the following confidential health information to LMC House call Program (address in header) from health care providers and facilities involved in my **current treatment and/or prior treatment within the past ___ months/years**, including primary care providers, specialists, hospitals, laboratories, and imaging centers. (If check, may use unless revoked. _____ initials)

_____

☐ Release of Medical Records to a Third Party *(one time use)*

I authorize and direct: LMC House Call Program, 204 W Trinity St, Groesbeck, TX 76642
To release the following confidential health information to (recipient):

Name/Organization: _____

Address: _____

Fax: _____ Email: _____

Reason: __ Auto/PPI insurance __ Attorney __ Disability __ Personal use
__ Other: _____

DATES OF SERVICE to release: __All dates OR From _____ to _____

INFORMATION TO BE RELEASED (check all that apply):

☐ 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

SENSITIVE INFORMATION (release ONLY if initialed):

☐ Mental health/behavioral health records ☐ HIV/STD info

☐ Alcohol/Drug treatment (SUD) records ☐ Other sensitive information: _____

DELIVERY METHOD (check one): ☐ Mail ☐ Fax ☐ Secure email

☐ Patient Portal ☐ Pick up in person ☐ Other: _____

If email is requested: Email address _____ I understand unencrypted email can be read by others.

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FEES: I understand there may be a charge for copies as permitted by Texas law, unless records are sent directly to another health care provider.

PATIENT RIGHTS AND HIPAA REQUIRED STATEMENTS:

1) I understand that I may revoke this authorization at any time by submitting a written request to the releasing facility's Health Information Management/Medical Records Department at the address above, except to the extent action has already been taken in reliance on this authorization.

2) I understand that this authorization is voluntary and that treatment, payment, enrollment, or eligibility for benefits are not conditioned by signing.

3) I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

4) I have the right to receive a copy of this signed authorization.

EXPIRATION: This authorization expires in 180 days from the date signed OR when a request to revoke has been signed.

SIGNATURES:

_____ _____ _____
Signature of Patient Printed name of Patient Date

OR

_____ _____ _____
Signature of legal representative Printed name of representative Date

Relationship/authority to act for patient _____

(If you sign as the patient's personal representative, you must describe your authority (e.g., parent of minor, legal guardian, medical power of attorney, executor of estate.)