



## LIMESTONE MEDICAL CENTER

701 McClintic Dr  
Groesbeck, TX 76642  
Tel: 254-729-3281 Fax: 254-3296

### 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 Limestone Medical Center (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: Limestone Medical Center, 701 McClintic Dr, 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):**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Demographic           | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Emergency Room Record  |
| <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Radiology Reports / CD |
| <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> EKG/CT scan/MRI/US | <input type="checkbox"/> Nurses' Notes          |
| <input type="checkbox"/> Pathology Report      | <input type="checkbox"/> Physician's Notes  | <input type="checkbox"/> Entire Chart           |
| <input type="checkbox"/> Billing Records       | <input type="checkbox"/> Immunization       | <input type="checkbox"/> 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  Other: \_\_\_\_\_ **PLEASE NO CDs**



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

**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:

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Signature of Patient

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Printed name of Patient

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Date

**OR**

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Signature of legal representative

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Printed name of representative

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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.)*