Rettig Family Health Care

A Limestone Medical Center Clinic

204 W. Trinity Street • Groesbeck, TX 76642 • Phone: (254) 729-3740 • Fax: (254) 729-8760

Authorization for Release of Medical Records

Patient Name: _____

Patient Address: _____

City, State, Zip: _____

Date of Birth: _____

This authorizes to release or disclose information from the records of the above-named patient to/from:

To: _____ From: _____

Address: _____ Address: _____

City/State: _____ City/State: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

The purpose of this disclosure is: _____

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.

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.

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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 1 (one) 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.)