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

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):

◻ 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 ◻ Other: _____ **PLEASE NO CDs**

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

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:

_____ _____ _____
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.)