



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: Complete only the sections that apply, DO NOT SIGN BLANK FORM

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

Release of Medical Records

I authorize and direct: LIMESTONE MEDICAL CENTER, 701 McClintic Dr, Groesbeck, TX

To release the following confidential health information to (recipient):

Name _____

Address: _____

Phone: _____ **Relationship to patient:** _____

Reason:

Auto/PPI insurance Attorney Disability Personal use

Other: _____

DATES OF SERVICE: 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 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 (12 months) from the date signed OR when a request to revoke has been signed.

SIGNATURES:

Signature of Patient	Printed name of Patient	Date
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OR

Signature of legal representative	Printed name of representative	Date
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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.)