Liberty-Dayton Regional Medical Center
1+353 N. Travis
Liberty, TX 77575
936-336-7316

Patient Name:_____
MR Number:_____
DATE OF SERVICE:_____
DOB/SSN#:_____

Authorization for Release of Patient Information

I request and authorize Liberty-Dayton Regional Medical Center to:

☐ **Release the following information to:**

_____
Name of Facility or Person

_____
Address/City, State, Zip

_____
Phone/Fax#

By: ☐ mail ☐ fax ☐ view ☐ pickup

Release is for the purpose of:

- ☐ Continued Care by other health care provider
- ☐ Insurance
- ☐ Attorney
- ☐ Disability
- ☐ School
- ☐ Personal Review
- ☐ Other (please specify)_____

☐ **Receive the following information from:**

_____
Name of Facility or Person

_____
Address/City, State, Zip

_____
Phone/Fax#

Information to be disclosed if requested:

- ☐ Complete medical record
- ☐ Radiology results/films_____
- ☐ Lab results
- ☐ Physician/PA/NP notes
- ☐ Nursing Notes
- ☐ Discharge instruction sheet
- ☐ Other (please specify)_____

I understand and agree that the information I am authorizing to be release may include: AIDS/HIV test results, diagnosis, treatment, and related information; Drug screen results and information about drug and alcohol use and treatment; and/or Mental health information unless other wise requested. _____(Patient's Initials)

I further understand that this Authorization is voluntary and I may refuse to sign this Authorization.

I further understand that I may revoke this Authorization at any time by notifying Liberty-Dayton Regional Medical Center, LLC (or the releasing facility) in writing, except to the extent that action has been taken in reliance on it. Unless earlier revoked, this Authorization expires automatically 180 days from the day signed.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

I further understand that I may refer to Liberty-Dayton Regional Medical Center's Notice of Privacy Practices.

RELEASE FROM LIABILITY I release and agree to hold harmless Liberty-Dayton Regional Medical Center (or other releasing facility) and its agents, representatives, and employees from any and all liability associated with the release of confidential

patient information in accord with this Authorization. I understand

Liberty-Dayton Regional Medical Center (or the releasing facility) can not be responsible for use or redisclosure of information to third parties.

TO THE RECEIVING PARTY OF THIS INFORMATION This information has been disclosed to you for the sole purpose(s) stated in this Authorization. Any other use of this information without the express written consent of the patient is prohibited. These records may be protected by federal regulation.

I certify that this form has been fully explained to me, that I have read it or had it read to me*, and that I understand its contents.

_____ _____ _____
Patient/Other Legally Authorized Person **Date** **Time**

_____
Print name and relationship to the patient

_____ _____
Witness/Translator* **Print Name**