LibertyDayton
REGIONAL MEDICAL CENTER

Authorization to Release Health Information

This form allows you to give written permission (called an "authorization") for your health information to be shared with someone else. We must have your authorization to share your information for reasons not related to your treatment, payment, or healthcare operations, unless allowed or required by law. Please read this form carefully before signing.

SECTION 1—Individual Whose Information Will Be Shared

Full Name: _____ Date of Birth: _____ / _____ / _____

SECTION 2—Who Can Release and Receive My Information? Please fill out the name and contact details of the person or organization you want us to send your information to.

Organization Releasing the Information	Authorized Recipient of Information
Name: **Liberty Dayton Regional Medical Center**	Name: _____
Address:**1353 N. Travis St. Liberty, TX 77575**	Address: _____
Phone: **936-336-7316**	Phone: _____
Fax (*if applicable*): **936-336-7837**	Fax (*if applicable*): _____
Email: **roi@libertydaytonrmc.com**	Email: _____

SECTION 3—What Information Can Be Shared? *Check all that apply*

☐ **All My Medical Records:** This includes all health information in my record, such as diagnoses, treatments, test results, medications, clinic notes, - unless I limit it below.

☐ **Records from This Date Range:** From: _____ / _____ / _____ To: _____ / _____ / _____

☐ **Records About a Specific Condition or Type of Care** (*describe*): _____

SECTION 4—Sensitive Health Information: Some health information has special legal protections. To authorize the sharing of any of the following, place your **initials** next to each category you approve. If you do not initial next to a category, we will **not** release the information.

Initial	Category	Description
_____	Mental/Behavioral Health	Includes evaluations, diagnoses, medications, or treatment for mental or behavioral health. Psychotherapy notes require a separate authorization.
_____	Substance Use Disorder (SUD) Records	Includes general information about substance use, such as ER visits, medications, or diagnoses. These records are protected by HIPAA but **are not** covered by the stricter protections of **42 CFR Part 2**. If the records are covered by **Part 2**, a separate consent form or court order is required to share them.
_____	HIV/AIDS-Related Information	Includes HIV status, test results, and related care. May require a separate authorization depending on state law.
_____	Genetic Information	Includes genetic test results, family history, or genetic counseling. Protected by HIPAA and the Genetic Information Nondiscrimination Act (GINA).
_____	Sexual/Reproductive Health	Includes birth control, fertility, STI testing, abortion services, and related care. Some disclosures may require additional steps, such as an attestation.
_____	Other (*describe*)	_____

SECTION 5—When Does This Authorization Expire? This authorization will expire when you choose, but if you don't select an option, it will be valid only for the one-time request.

☐ After this one-time request is completed ☐ One (1) year from the date of my signature _____

SECTION 7—Your Rights and Important Information

By signing this form, you acknowledge that you understand the following:

- The recipient may share your information again. Once your information is shared with someone else, they may not be required to follow the same privacy rules (like HIPAA).
- You can cancel this authorization at any time, and canceling will not affect any information already shared based on this form. To do so, write to: **roi@libertydaytonrmc.com or Call 936-336-7316 x. 143**
- You have a right to a copy of this signed form. Keep it for your records

_____ _____

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Signature of Individual or Authorized Representative | Date

Printed Name of Authorized Representative (*if not signed by the individual*) | Relationship to Individual

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For Office Use Only

Date Received: _____ / _____ / _____

Processed By: _____