Authorization To Disclose Health Information
Lonestar Medical

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I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: ____ Date of Birth: ________________________

I authorize the following provider or organization to disclose the above named individual's health information:

____

Address**:** ____

Phone/Fax: ____

This information may be disclosed to and used by the following Dr. Jay L. Gruhlkey for the following reason:
Transfer Care/Follow up Treatment/Other ____________________________

Please release the following:

_____Entire Record

OR:

_____Problem List
_____Progress Note
_____History/Physical Exam
_____Medication List
_____Immunization Record
_____List of Allergies

_____X-Ray/Imaging Reports from _________ to ________
_____Laboratory Results from ________ to ________
_____EKG report
_____Genetic Testing Information
_____Other Diagnostic Report ________________________
_____Other _______________________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
_____**Yes,** I consent to the release of this information. _____**No,** I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: ________________________.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact **Lonestar Medical at 830-626-9911.**

______________________________________ _________________
Signature of Patient or Legal Representative Date

______________________________________ _______________________________________
Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Jay L. Gruhlkey MD PA d.b.a. Lonestar Medical liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____________________________________ _______________
Signature of Patient or Legal Representative Date

_____________________________________ _______________
Relationship to Patient (If Legal Representative) Witness

Date Completed __________________ # of pages copied ______________________ Reviewed only _______________

Charges $ __________ Cash __________ Check # _________ Other __________ Initials __________