Lemon-AID
Medical Management

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This form authorizes Lemon-AID Medical Management to release your medical records to a person or organization you choose. Please complete every section and sign at the end. We cannot process an incomplete or unsigned form, and we will contact you if anything is missing.

SECTION 1: PATIENT INFORMATION

Name of Patient (Printed) _____

Date of Birth _____

Former / Other Names _____

Address _____

City, State, ZIP _____

Phone _____

E-mail _____

SECTION 2: RELEASE MY RECORDS TO

_____ Release my records to me (the patient). _____ Release my records to the person or organization below.

Recipient Name _____

Attention / Contact _____

Address _____

City, State, ZIP _____

Phone _____

Fax _____

E-mail _____

If I want my records sent to more than one recipient, I understand that I must complete a separate form for each recipient.

SECTION 3: RECORDS TO BE RELEASED

Mark each item I want released:

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_____ Complete medical record (recommended)

_____ Records for dates of service from _____ / _____ / _____ to _____ / _____ / _____

_____ Office notes, progress notes, and consultation notes _____ History and physical

_____ Laboratory and pathology results _____ Imaging and radiology reports

_____ Medication list and prescription history _____ Immunization record

_____ Problem list and diagnoses _____ Weight management treatment records

_____ Billing and account records _____ Most recent visit only

_____ Other (describe): _____

SECTION 4: SENSITIVE INFORMATION

Texas and federal law require my separate, specific written permission before certain categories of information may be released. Records in these categories WILL NOT be released unless I place my initials on the line next to that category below. Leaving a line blank withholds that category.

_____ HIV and AIDS testing, test results, and diagnosis

_____ Sexually transmitted infections

_____ Mental and behavioral health information (this does not include psychotherapy notes)

_____ Substance use disorder evaluation and treatment records

_____ Genetic testing information

I understand that psychotherapy notes kept separately from the rest of my record cannot be released using this form and require a separate authorization that covers only those notes.

I understand that substance use disorder treatment records are also protected by federal law (42 C.F.R. Part 2), that federal law prohibits the recipient from making any further disclosure of those records unless further disclosure is expressly permitted by my written consent or is otherwise permitted by that law, and that a general authorization for the release of medical information is NOT sufficient for this purpose.

SECTION 5: PURPOSE OF THE DISCLOSURE

_____ At my request (I am not required to give any further explanation)

_____ Continuing medical care or transfer of care to another provider

_____ Insurance, disability, or benefits determination _____ Legal purposes

_____ Personal records _____ School or employment

_____ Other (describe): _____

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SECTION 6: HOW THE RECORDS SHOULD BE SENT

_____ Secure electronic delivery or patient portal _____ Mail to the address in Section 2

_____ Fax to the number in Section 2 _____ Pick up in person (government-issued photo identification required)

_____ Encrypted e-mail _____ Unencrypted e-mail to the address in Section 2

I understand that fax and unencrypted e-mail are not secure methods of delivery, that information sent this way could be intercepted, misdirected, or read by someone other than the intended recipient, and that Lemon-AID Medical Management is not responsible for a disclosure that results from my choosing one of those methods. If I select fax or unencrypted e-mail, I accept that risk. I am responsible for confirming that the number or address I provided is correct.

SECTION 7: WHEN THIS AUTHORIZATION EXPIRES

This authorization remains in effect until I revoke it in writing.

If I want it to end sooner, I may write an earlier expiration date or event here:

_____

I understand that federal law requires every authorization to state an expiration date or event, and that by signing this form without writing an earlier one, I am choosing an authorization that continues until I revoke it (recommended).

SECTION 8: MY RIGHTS

- I may revoke this authorization at any time by giving Lemon-AID Medical Management a signed, written revocation. Revocation takes effect when it is received and does not apply to any disclosure already made in reliance on this authorization.
- Lemon-AID Medical Management will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I sign this form.
- I have the right to receive a copy of this authorization after I sign it.
- I have the right to inspect and receive a copy of the records that will be disclosed under this authorization.
- Information disclosed under this authorization may be re-disclosed by the person or organization that receives it and may then no longer be protected by federal or state privacy law.
- I may ask questions about this form before I sign it, and I should not sign it if there is anything in it I do not understand.

SECTION 9: FEES

Lemon-AID Medical Management may charge a reasonable fee for copying, compiling, and sending records, as permitted by Texas law and Texas Medical Board rules. I will be told the amount before the records are released, and records may be held until the fee is paid. No fee will be charged where the law prohibits one, including when my records are sent to another health care provider for my continuing care.

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SECTION 10: HOW LONG THIS TAKES

Texas law requires a physician to furnish requested records not later than the 15th business day after receiving a valid written authorization. Lemon-AID Medical Management will process my request within that period, and often sooner. If any part of my request is denied, I will be given the reason in writing.

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SECTION 11: SIGNATURE

I have read and understand this authorization. I am signing it voluntarily. I authorize Lemon-AID Medical Management to release the records I identified above, including only the sensitive categories I initialed, to the recipient I named, in the manner I selected.

If signed by someone other than the patient, complete the following:

Relationship to patient: _____

Basis of authority (check one):

_____ Parent of a minor patient

_____ Court-appointed guardian or managing conservator (documentation provided)

_____ Agent under a medical power of attorney (documentation provided)

_____ Executor or personal representative of a deceased patient's estate (documentation provided)

_____ Other legal authority (describe): _____

By signing, I represent that I have legal authority to authorize the release of this patient's records, that I have provided documentation of that authority, and that I will notify Lemon-AID Medical Management immediately if my authority changes or ends.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date
_____	_____	_____
If Not Patient: Name (Print)	Signature	Date

FOR OFFICE USE ONLY

Request Processing	Date	Staff Initials
Form received	_____ / _____ / _____	_____
Patient identity verified	_____ / _____ / _____	_____
Authority documentation verified	_____ / _____ / _____	_____
Fee quoted / collected	_____ / _____ / _____	_____
Records released	_____ / _____ / _____	_____

Method of release: _____ Portal _____ Mail _____ Fax _____ Encrypted e-mail _____ In person _____ Other: _____

Number of pages released: _____ Released by: _____

Notes:

_____

A copy of this completed authorization has been placed in the patient's medical record, and a copy was provided to the patient.

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