Dear Patient,

Lone Star Circle of Care is required by law to maintain your medical records and allow you to access those records. To better serve our patients, HealthMark Group is now the Release of Information partner for Lone Star Circle of Care, and they will fulfill all requests for copies of medical records.

Although we are permitted to charge a reasonable, cost-based fee for this service, Lone Star Circle of Care and HealthMark Group are waiving these fees for all Lone Star Circle of Care patients. If you would like to receive a copy of your medical records, you may do so via any of the following methods:

- **Immediate Digital Access via the Patient Portal.** Visit the Lone Star Circle of Care website at www.lonestarcares.org and select Patient Portal from the top right corner. Sign in to your account and immediately access, download, or print your records. If you need assistance accessing your account, please contact Lone Star Circle of Care at 1-877-800-5722. Please be aware that the portal does not contain your full medical record. For example, your visit notes, scanned documents and forms, and records we receive from other providers will not be displayed on the site. For a complete copy of your medical record follow the instructions below.
- **Request Digital Copies of your FULL Medical Record.** Visit www.HealthMark-Group.com, select "Requestors", login to the MedRelease tool (note: if it is your first time using this tool, you will need to create an account). Once logged in click "Submit Request" to complete the HIPAA Compliant Electronic Authorization. After the Electronic Authorization Form has been completed click "Authorize Release" at the bottom of the page.
- **Fill out a paper authorization form and send it to us by mail, fax, or in person**. A copy of this form may be provided by Lone Star Circle of Care staff at any location. You may also find this from on the Lone Star Circle of Care website at www.lonestarcares.com (click the link on the home page that says "Request Medical Records"). You may return this form to any Lone Star Circle of Care location or submit your request as follows:

Fax: 833-449-4641

Request by Mail:
Lone Star Circle of Care
2423 Williams Dr. Suite 107
Georgetown, TX 78626

Your records will be released as specified by you in the Authorization form. Once processed, you will receive a notification via email or standard USPS delivery with instructions on how to retrieve your records. *To expedite the delivery of your records, please provide your email address on your authorization.*

To check the status of a previously submitted request please contact HealthMark Group directly by phone at 800-659-4035 or by email at status@healthmark-group.com.

Thank you for choosing Lone Star Circle of Care as your healthcare home!

Lone ★ Star
Circle of Care

Authorization to Disclose, Use or Release Protected Health Information

This authorization form is HIPAA-compliant and meets all state and federal regulatory requirements, including Federal Law 45 CFR § 164.508.

Individual/Patient (Name & Information of person whose protected health information is being disclosed).

Name/Other Names Previously Used	Date of Birth	Last Four Digits of Social Security #

Address City State ZIP	Telephone #	Email Address

Authorization (in the space below, identify the person or organization you want to receive the information)

I authorize Lone Star Circle of Care and its affiliated clinics to disclose my protected health information, which may be oral, electronic or written, to the persons or organizations listed below:

Persons/Organizations authorized to receive information	Relationship

Address City State ZIP	Telephone #	Fax #

Purpose(s) (You must check at least one box below).

- ☐ Legal/Needed for attorney
- ☐ Continuing care or treatment / specialist referral
- ☐ Moving out of the area
- ☐ Application for federal, state, or local services
- ☐ Other - Please describe: _____
- ☐ Moving to new primary care provider / OB/GYN / Behavioral healthcare provider
- ☐ Insurance
- ☐ Personal Use
- ☐ I am making this request and authorization but choose not to list the purpose of disclosure

Description of Information to be Disclosed

The protected health information or records may include, but is not limited to, information regarding communicable diseases, HIV, AIDS, psychiatric & psychological information, mental health or mental illness, genetic testing, chemical or alcohol dependency or abuse, laboratory tests results, and/or other sensitive health information. I authorize the release of the above-named information unless otherwise noted in special instructions below.

- ☐ Complete medical record (includes labs and immunizations)
- ☐ Specific date(s) of services (if not requesting entire chart): _____
- ☐ Immunizations only
- ☐ Do Not release mental health records
- ☐ Special Instructions: _____
- ☐ Lab Tests/Results only
- ☐ History/Physical/Well-check only
- ☐ Billing records only
- ☐ Other – Please describe: _____

Signature

I understand that I may revoke this authorization at any time by giving written notice to Lone Star Circle of Care ("LSCC"), c/o Privacy Officer at the following address: LSCC, 205 E. University Ave., Suite 200, Georgetown Texas, 78626. I understand that revocation of this authorization will not affect any action that LSCC took in reliance on this authorization before receiving my written notice of revocation. I understand that information released or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected under HIPAA privacy regulations. I understand that this authorization is voluntary and that LSCC cannot condition my eligibility for benefits or treatment on the signing of this authorization. This authorization will expire one year from date signed unless otherwise noted.

Signature of Patient/Individual or Personal/Legal Representative	Date Signed

Relationship/Authority as Personal Legal Representative (Please provide applicable legal documentation).