Kelsey-Seybold Clinic

Authorization for Release of Healthcare Information

Patient Name:
DOB:
KSC No:.

FAX #:

I hereby authorize the transfer/receipt of the following healthcare information:

TO: _____ FROM: _____

_____ _____

_____ _____

Phone: _____ Phone: _____

☐ Discharge Summary	☐ Psychiatric Assessment	☐ Immunization Record
☐ History & Physical Exam	☐ Initial Intake	☐ X-Ray Reports
☐ Progress Notes	☐ Psychosocial History	☐ Complete Record
☐ Consultation Reports	☐ Psychological Reports	☐ Laboratory Reports
☐ Operative Reports	☐ Treatment Plan	☐ Other (Specify)_____

Purpose of Disclosure: ☐ Continuing Patient Care ☐ Other _____

I understand that specific information to be released may include, but is not limited to history, diagnosis and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. The revocation must be in writing and delivered to the Kelsey-Seybold Medical Record Department. It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

THIS CONSENT WILL EXPIRE 180 DAYS AFTER DATE OF SIGNATURE.

_____ _____

(Signature of Patient) (Date) (Signature of Patient's Representative) (Date)

_____ _____

(Witness) (Date) (Relationship to Patient)