

K Kelsey-Seybold Clinic
St. Luke's Episcopal Health System

Authorization for Release of Healthcare Information

FAX #:

Patient Name:
DOB:
KSC No.:

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

TO: _____

FROM: _____

Phone: _____

Phone: _____

- | | | |
|--|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychiatric Assessment | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Initial Intake | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Psychosocial History | <input type="checkbox"/> Complete Record |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Psychological Reports | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> 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. Kelsey-Seybold Clinic, its employees and partners and providers are released from legal responsibility for the release of the above information to the extent indicated and authorized herein.

THIS CONSENT WILL EXPIRE 180 DAYS AFTER DATE OF SIGNATURE.

(Signature of Patient) (Date)

(Signature of Patient's Representative) (Date)