



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:
[Blank lines for recipient and sender information]

Phone: Phone:
[Blank lines for recipient and sender phone numbers]

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