# Kelsey-Seybold Clinic

**Authorization for Release of Healthcare Information**

Patient Name: _____
Other names used: _____
DOB: _____
KSC No: _____

**FAX #: 713-442-6376**
**PHONE #: 713-442-6334**

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

To:

Kelsey-Seybold Clinic
2727 West Holcombe Blvd.
Houston, TX 77025
Attn: 2nd Floor Mammography Department

Name & address of previous breast imaging facility:

_____
_____
_____
PHONE: _____

- ☐ Mammogram CD (in DICOM format) or films & report
- ☐ Breast ultrasound CD & report
- ☐ Stereotactic or ultrasound biopsy CD & report
- ☐ Breast MRI CD & report

Purpose of Disclosure:

- ☐ Continuing Patient Care
- ☐ Temporary release of disclosed information for comparison reasons or outside film reading
- ☐ Permanent release of disclosed information to be kept at Kelsey-Seybold Clinic
- ☐ 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)

☐ **OUTSIDE FACILITY**: If unable to locate previous records on this patient, please check the box and fax this form back to 713-442-6376 or contact us at 713-442-6334.