Kelsey-Seybold Clinic®
Changing the way health cares.℠

PERMISSION TO COMMUNICATE PHI

By filling out this form and signing below:

I give Kelsey-Seybold permission to share and discuss my health history with the designated person(s) listed below. I understand this may include sensitive details, such as:

- Transmissible illness testing and/or treatment, including HIV/AIDS
- Drug and alcohol abuse
- Behavioral and mental health issues

This permission will only expire if I cancel or change it. I can cancel or change it at any time. Changes must be made in writing and sent to Kelsey-Seybold at the address on this form. I understand that changes or cancellations:

- Will not affect information already shared with my designated person(s)
- Will not begin until Kelsey-Seybold receives my written request

If I want to change my designated person(s), I must complete a new form. I understand that when I fill out a new form, my old form is no longer valid. I understand that my designated person(s) may share information with others, and if done without my permission, federal law may not protect those actions. I do not need to sign this form to make sure I get treatment. This form does not authorize the release of my medical records.

My information (patient)

Name:_____ Date of Birth:_____

Street:_____ City:_____ State:_____ Zip:_____

My Designated Person(s)'s Information: Please list your designated person(s).

1. Name:_____ Relationship to Patient:_____
   Telephone #:_____
2. Name:_____ Relationship to Patient:_____
   Telephone #:_____
3. Name:_____ Relationship to Patient:_____
   Telephone #:_____

Please return by one method. Allow 3 business days upon receipt for form upload to your medical record.

Encrypted email: ROI@Kelsey-Seybold.com | **Fax line:** 713-442-2804

Mail:
Kelsey-Seybold Clinic, ATTN: Medical Records Department
560 Meyerland Plaza Mall
Houston, TX 77096

_____ _____
Signature of Patient or Legal Representative Date

_____
If signed by Legal Representative, relationship to patient