PERMISSION TO COMMUNICATE PHI

Kelsey-Seybold, on behalf of itself and affiliated companies, cannot share Protected Health Information (PHI) without your consent. By signing this form, you are providing written consent for Kelsey-Seybold to share, communicate, or discuss your PHI with someone designated by you; not the right to make any decisions for you. I understand this may include sensitive details such as: Transmissible illness testing and/or treatment, including HIV/AIDS, drug and alcohol use, behavioral and mental health issues. This form allows us to communicate your PHI, to this designated person(s), named in Section 2 below.

1. Patient Information (please provide current information)

Last Name:	First Name:		MI:
Mailing Street Address:			Apt. #:
City:		State:	ZIP:
Phone #:	Date of Birth:	Email:	

2. Designated person/representative information

I, the undersigned, authorize Kelsey-Seybold to share, communicate, or discuss my PHI with the person(s) designated below. I understand that my healthcare providers must protect the privacy of my PHI under federal or related state laws and are unable to disclose this information without my consent.

Authorized Person/Representative #1	
Name:	Phone Number:
Date of Birth:	Relationship to Patient:

Authorized Person/Representative #2	
Name:	Phone Number:
Date of Birth:	Relationship to Patient:

3. Signature of Patient/Authorized Representative Signature

I have read and understand the above. By signing this form, I am voluntarily giving consent to Kelsey-Seybold and its affiliates to share, communicate, or discuss my PHI with the person(s) designated above in Section 2. I understand this request will stay in place until I notify Kelsey-Seybold otherwise using the contact information in Section 4 below and will not affect information already shared with my representative(s).

Patient OR Authorized Representative Printed Name:	
Authorized Representative Relationship/Authority:	
Signature:	Date:

4. Please return as follows:

Encrypted Email to: ROI@Kelsey-Seybold.com	Fax line: 713-442-2804
Mail: Kelsey-Seybold Clinic ATTN: Medical Records Department 560 Meyerland Plaza Mall Houston, TX 77096	• Please allow 3 business days for this form to upload to your medical record.