Kelsey-Seybold Clinic

Authorization for Release of Healthcare Information

Patient Name: _____ Home Address: _____

Date of Birth: _____ _____

Phone: _____

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

Release To: _____ **Obtain From:** _____

_____ _____

_____ _____

Phone: _____ **Phone:** _____

Fax: _____ **Fax:** _____

Date(s) of Service: _____ **through** _____

- ☐ Complete Record
- ☐ Progress Notes
- ☐ History & Physical Exam
- ☐ Consultation Reports
- ☐ Operative Reports
- ☐ Other (please specify) _____
- ☐ Immunization Record
- ☐ Pathology Reports
- ☐ Discharge Summary
- ☐ Laboratory Reports
- ☐ Radiology Images and Reports (please specify) _____ _____
- ☐ Breast Images and Reports (including mammography, breast ultrasound, MRI, and biopsy)

Purpose of Disclosure: ☐ Continuity of Care ☐ Legal ☐ Personal Use ☐ Financial/Benefits ☐ Other (please specify) _____

☐ **For Medical Records**

- *Send Encrypted Email with Records to*: ROI@Kelsey-Seybold.com
- *Secure Fax Line*: 713-442-2804
- *Mail records to:* Kelsey-Seybold Clinic, Medical Record Department, 560 Meyerland Plaza Mall, Meyerland, Texas 77096

☐ **For Radiology Only**

* *Send Encrypted Email with Records to*: RadiologyROI@Kelsey-Seybold.com
* *Secure Fax line:* 713-442-1175
* *Mail Records to:* Kelsey-Seybold Clinic, Radiology Department, 2727 West Holcombe Blvd., Houston, Texas 77025

The following items are Statutorily Protected information and require your special consent by law.

Check the boxes to include the following in this request:

- ☐ Alcohol or Substance Abuse
- ☐ Mental or Behavioral Health
- ☐ Genetic Information
- ☐ Reproductive Health
- ☐ HIV/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 | Printed Name | Date

Signature of Patient's Representative | Printed Name of Representative | Date