

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

- I hereby authorize Seton Medical Center to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization.
- I understand that this authorization will expire 180 days from the date of signature, unless otherwise revoked. I further understand that I may revoke this authorization at any time by notifying, in writing, Seton Medical Center. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.
- I understand the record might not be complete. If a recent visit, additional information could be added after submitting requested records.
- I understand that this information may include information relating to: AIDS, HIV, diagnosis/treatment of drug or alcohol abuse; mental, behavioral health, or psychiatric care.
- I understand information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.
- I understand that applicable fees may apply, as permitted by Texas law. The fee required for this request is \$ \_\_\_\_\_

<b>Patient Information</b>	<b>Patient Name</b>			
	<b>Address</b>			
	<b>City/State/Zip</b>			
	<b>Date of Birth</b>	/	/	<b>Phone #</b>
	<b>Email Address</b>			

<b>Receiving Facility / Individual Information</b>	<i>Please release information TO the following individual / facility:</i>		
	Individual/Organization Name		Telephone #
	Street Address	City, State Zip	Fax #

<b>Indicate Specific Information To Be Released</b>	<input type="checkbox"/> Summary Abstract (H&P, consultations, discharge summary, test results, procedure reports, pathology)		
	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Emergency Department	<input type="checkbox"/> Laboratory
	<input type="checkbox"/> History/Physical	<input type="checkbox"/> Operative Report(s)	<input type="checkbox"/> Radiology Images
	<input type="checkbox"/> Pathology	<input type="checkbox"/> Radiology Reports	
	<input type="checkbox"/> Other: _____		
	Date(s) of Service: _____		

<b>Record Copy Format:</b>	<input type="checkbox"/> Paper	<input type="checkbox"/> CD	<b>Delivery Method:</b>	<input type="checkbox"/> My Chart	<input type="checkbox"/> Email	<input type="checkbox"/> Fax	<input type="checkbox"/> Pick Up	<input type="checkbox"/> Mail
	_____							

<b>Purpose of Request</b>	<input type="checkbox"/> Continued Care	<input type="checkbox"/> Legal	<input type="checkbox"/> Insurance / Disability / SSI	<input type="checkbox"/> Personal	<input type="checkbox"/> _____
	_____				

\_\_\_\_\_  
Signature of Patient/Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to patient, if other than self  
(attach appropriate legal documents)

**For Hospital Staff use:**

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