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
- ☐ Immunization Record
- ☐ X-Ray Reports
- ☐ Discharge Summary
- ☐ Laboratory Reports
- ☐ Other (please specify) _____

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

Method of record submission to Kelsey-Seybold Clinic

- *Send Encrypted Email with Records to*: ROI@Kelsey-Seybold.com
- *Secure Fax line*: 713-442-2804
- *Mail records to:* Kelsey-Seybold Clinic
  Release of Information Dept.
  560 Meyerland Plaza Mall
  Houston, Texas 77096

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)