Seton Medical Center Harker Heights
A partner of the Seton Healthcare Family

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RELEASE OF INFORMATION FORM

Patient Identification

Printed Name: _____ Date of Birth:_____
Address:_____
_____
Social Security #: _____Telephone:_____

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____
From (date) _____ to (date) _____

Please check type of information to be released:

▪ Entire medical record	▪ Pathology report	▪ Discharge summary
▪ History and physical exam	▪ Consultation reports	▪ Progress notes
▪ Laboratory test results/reports	▪ X-ray reports	▪ X-ray films/images
▪ Operative report	▪ Emergency room record	▪ Itemized bill

▪ Other, (specify) _____

Purpose of Request

▪ Treatment or consultation	▪ At the request of the patient	▪ Billing or claims payment

Person Authorized to Receive Information

Name: _____
Address:_____
_____

Drug and/or Alcohol Abuse and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check One:*** ▪ Yes ▪ No __ Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. ***Check One:*** ▪ Yes ▪ No _____ Initials

Time Limit and Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at *[location and mailing address]*. Unless revoked, this authorization will expire on the following date or event _____.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that *[Name of Facility]* may not condition my treatment on whether I sign this authorization form unless specified above under Purposes of Request. I can inspect or copy the protected health information to be used or disclosed and shall receive a copy of this authorization. **I authorize** _____ **to use and disclose the protected health information specified above.**
(Name of Facility or Provider)

Signature: _____ Date: _____
Authority to Sign if not patient: _____
Identity of Requestor Verified via**: ▪ Photo ID ▪ Matching Signature ▪ Other, specify** _____
Verified by: _____

Email Address: _____