Authorization for Release of Patient Health Information

I hereby authorize _____ to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this *authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.*

I understand that if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name | Date of Birth | Social Security Number

Date(s) of Service (if known) | Medical Record #

Description of information to be released: (check all that apply)

___Face Sheet
___Discharge Summary
___History & Physical
___Consultation Reports
___Operative Reports

___Radiology Reports
___Laboratory Reports
___Pathology Reports
___Diagnostic Reports
(i.e. EKG,EEG, Sleep Study)

___Radiology Films (Imaging Department)
___Billing Records (Patient Financial Services)
___Emergency Room
___Other:_____
_____

The purpose of the disclosure is for the following (check the appropriate category);

☐ **Patient Request (Circle type of disclosure)** Hospital Physician Insurance Attorney
Other: Please explain_____

☐ **Hospital Request**. Explain purpose of Authorization _____
(If a hospital Request the patient must receive a copy of the authorization)

The information described herein will be sent to the following address; (if applicable)

Seton Spine and Scoliosis Center 1600 West 38th Street, Suite 200, Austin, TX 78731

Name | Address | City | State | Zip

I understand that this authorization will expire 365 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____.
(Expiration event/date)

I understand that I may revoke this Authorization by requesting a written revocation of authorization that can be obtained by calling/writing: _____.
I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative | Date

_____
Printed name of Patient's Representative

_____ or _____
Relationship to Patient | Legal Authority (attach supporting documentation)