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

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 $_____

Patient Information	**Patient Name**			
	Address			
	City/State/Zip			
	Date of Birth	/ /	**Phone #**	
	Email Address			

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

Indicate Specific Information To Be Released

- ☐ Summary Abstract (H&P, consultations, discharge summary, test results, procedure reports, pathology)
- ☐ Discharge Summary
- ☐ History/Physical
- ☐ Emergency Department
- ☐ Operative Report(s)
- ☐ Pathology
- ☐ Laboratory
- ☐ Radiology Images
- ☐ Radiology Reports
- ☐ Other:

Date(s) of Service:

Record Copy Format:	☐ Paper	☐ CD	**Delivery Method:**	☐ My Chart	☐ Email	☐ Fax	☐ Pick Up	☐ Mail

_____

Purpose of Request	☐ Continued Care	☐ Legal	☐ Insurance / Disability / SSI	☐ Personal	☐ _____

_____ _____
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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