Seton
Family of Hospitals
Austin, TX 78705

AUTHORIZATION FOR RELEASE OF INFORMATION

Print Patient Name	Date of Birth
Social Security Number	Medical Record Number
Date(s) of Service (if known)	

I hereby authorize:

☐ Dell Children's Medical Center of Central Texas
☐ Seton Edgar B. Davis Hospital
☐ Seton Highland Lakes Hospital
☐ Seton Medical Center Austin
☐ Seton Medical Center Hays
☐ Seton Medical Center Williamson
☐ Seton Northwest Hospital
☐ Seton Southwest Hospital
☐ University Medical Center Brackenridge
☐ _____

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 covered entity, e.g. insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations.

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)

_____

Name Address City State Zip

I understand that this authorization will expire 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____
(Expiration event/date)

I further understand that I may revoke this authorization at any time by notifying SETON in writing at

☐ Dell Children's Medical Center of Central Texas, 4900 Mueller Blvd., Austin, Texas 78723
☐ Seton Edgar B. Davis Hospital, 130 Hays Street, Luling, Texas 78648
☐ Seton Highland Lakes Hospital, P.O. Box 1219, Burnet, Texas 78611
☐ Seton Medical Center Austin, 1201 West 38th, Austin, Texas 78705
☐ Seton Medical Center Hays, 6001 Kyle Parkway, Kyle, Texas 78640
☐ Seton Medical Center Williamson, 201 Seton Parkway, Round Rock, Texas 78665
☐ Seton Northwest Hospital, 11113 Research Blvd., Austin, Texas 78759
☐ Seton Southwest Hospital, 7900 FM 1826, Building 1, Austin, Texas 78737
☐ University Medical Center Brackenridge, 601 East 15th Street, Austin, Texas 78701

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)

FOR STAFF USE ONLY

Date request completed_____ # of pages released _____

Staff Name _____

325 Release of Info

(1/10) Print Request