dell children's
medical center of central texas
A member of the Seton Family of Hospitals

DELL CHILDREN'S EYE CENTER
Seton Northwest Office Building
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Austin, TX 78759
Tel: 512.324.6755 Fax: 512.324.6753
M. Hillary Onan, MD- A. Melinda Rainey, MD- Lee Woodward, MD- Lani Hoang, MD

Patient Name: _____Date of Birth: _____
Patient Phone #:_____ MRN/Acct #: _____

AUTHORIZATON FOR RELEASE OF PATIENT INFORMATION

****

I, the patient named above or his/her parent/legal representative, hereby authorize the Clinic named above to:

☐ Release To:	☐ Obtain From:	Date Range:
Name of Entity/Person:		From: To:
Address:		Phone:
City, State & Zip:		Fax:

The following individually identifiable health information for the purpose(s) identified below:

Information (check one or more):		**For the Purpose Of (check at least one):**
☐ Immunization record	☐ Medication List	☐ Disability
☐ Lab/pathology reports	☐ Diagnostic reports	☐ Legal/Attorney
☐ Office Visit Notes*	☐ Billing Records	☐ Insurance
☐ Complete clinical record (Does not include billing records)*		☐ School
☐ Alcohol/Substance Abuse records (42 CFR Part 2)		☐ General/Nonspecific Patient Request
☐ Other (Specify): _____		☐ Other (Specify): _____

NOTICE TO RECIPIENT: Federal rules **prohibit further disclosure by the recipient of any alcohol or substance abuse records** released under this Authorization unless the recipient has received written consent from the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Acknowledgments: I understand and acknowledge that:

1. Individually identifiable health information may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (*except psychotherapy notes), genetic testing, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information.
2. I do not have to sign this Authorization and that my refusal to sign will not affect by ability to receive health care services or items.
3. The entity or person receiving information under this Authorization may not be subject to HIPAA or state privacy rules and the information released may no longer be protected by federal or state privacy rules.
4. I may cancel this Authorization at any time by submitting a written notice of revocation to the Clinic at the address listed in the upper left hand corner. The revocation will not affect any use or disclosure by the Clinic before receipt of the written revocation.

EXPIRATION: Authorization expires 180 days from the date signed or the following:_____

(Date or Event)

_____ _____ _____

Date Signature of Patient or Patient's Representative Printed Name of Patient's Representative

Relationship to Patient *(if requestor is not the patient)* ☐ Parent ☐ Legal Guardian* ☐ Other*:_____

*Attach legal document

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FOR STAFF USE ONLY

Date request received: _____ Date request completed: _____ # of pages released: _____

Staff Name: _____ ☐ Paper Copies ☐ Electronic Copy