Ascension Seton
Austin, Texas 78723

PATIENT LABEL

AUTHORIZATION FOR RELEASE OF INFORMATION

Purpose of Request: Check Only One Box Per Request
☐ Printed Paper Release of Records
☐ Electronic Release of Records (see additional instructions)

Patient Name:	Date of Birth:	SS #:	Phone #: ( )

Current Mailing Address:

Mail in or present your request in person at the applicable site location(s).
I hereby authorize Ascension Seton to release my records from the following facilities:

☐ Dell Children's Medical Center
4900 Mueller Blvd
Austin, TX 78723

☐ Ascension Seton Medical Center Austin
1201 West 38th
Austin, TX 78705

☐ Ascension Seton Northwest
11113 Research Blvd
Austin, TX 78759

☐ Ascension Seton Edgar B. Davis
130 Hays Street
Luling, TX 78648

☐ Ascension Seton Hays
6001 Kyle Parkway
Kyle, TX 78640

☐ Ascension Seton Southwest
7900 FM 1826
Austin, TX 78737

☐ Ascension Seton Highland Lakes
P.O. Box 1219
Burnet, TX 78611

☐ Ascension Seton Williamson
201 Seton Parkway
Round Rock, TX 78665

☐ Dell Seton Medical Center at The University of Texas
1500 Red River Street
Austin, TX 78701

☐ Ascension Seton Smithville
800 TX-71
Smithville, TX 78957

Release to: Please provide name and destination of the person/organization to which this release is to be made.

Name: _____

Address (to include City, State, & Zip): _____

Email Address (electronic): _____

Phone #: _____

Range of Service Dates to be released **(required):** _____

For the following purpose: ☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Disability ☐ VA

Select portions of the Protected Health Information to be released 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 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.

☐ Abstract/Summary
☐ Discharge Summary
☐ History & Physical
☐ Diagnostic Reports (ex: EKG, EEG, Sleep Study)
☐ Operative/Procedure Reports
☐ Radiology Reports
☐ Radiology Films **(only available in Imaging Dept.)**
☐ Compete Record
☐ Laboratory Reports
☐ Pathology Reports
☐ Face Sheet
☐ Consultation Reports
☐ Emergency Room
☐ Other: _____
☐ Billing Records **(only available in Patient Financial Services)**

This authorization is valid until the 180th day after the date it is signed unless I otherwise specify or unless it is revoked in writing. I understand revoking my authorization will only cover treatment(s) for the dates specified above. I desire this authorization to be in effect until _____.

I, the undersigned, have read the above and authorize the staff of Ascension Seton to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

_____ _____ _____
Signature of Patient/Parent/Representative/Guardian | Date | Authority/Relationship to Patient

Fees/charges will comply with all laws and regulations applicable to release of Protected Health Information. Records may be released after full payment has been received.

FOR STAFF USE ONLY
Date request received _____ Date request completed _____
# of pages released if printed _____
Staff Name: _____