Seton Shoal Creek Hospital
A member of the Seton Healthcare Family
HEALING FOR LIVES IN CRISIS
Austin, TX 78731

Addressograph

Pt. Name: Age: Sex:

Physician: MR #:

Patient #: Site:

AUTHORIZATION FOR RELEASE OF PATIENT BEHAVIORAL HEALTH INFORMATION

I hereby authorize ***Seton Shoal Creek Hospital*** to

_____ **Disclose to** _____ (Person/Entity)
_____ **Obtain from** _____ (Address)
_____ (City, State, Zip Code)
_____ (Telephone)
_____ (Fax Number)

My behavioral health information as described below. I understand that this authorization extends to all or any part of the records, which may include treatment for physical and mental illness (except for psychotherapy notes), chemical or alcohol dependency, communicable disease such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS") test results or diagnoses. I understand that my records may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws, and cannot be disclosed without my written consent at any time. I understand this consent is subject to revocation at any time, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as indicated below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and payment of my health care will not be affected if I do not sign this form.

Print Patient Name **Date of Birth** **Social Security Number**

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

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

____ Discharge Summary	____ Admission Notes	____ Billing/Financial Record
____ Treatment Plan	____ Progress Notes	____ Medication Records
____ Laboratory Reports	____ Physician Progress Notes	____ Physician Orders/Discharge
____ Radiology Reports	____ Mental Status Exam	____ Verbal Communication with:
____ Diagnostic Reports	____ Psychological Testing	_____ (Name)
____ Consultation Reports	____ History & Physical Exam	_____ (Relationship)
____ Other _____		

The purpose of the disclosure is for the following: *(Initial the appropriate category)*
Patient Request:

____ **Continuity of Care** _____ **Personal Information** ____ **Legal Purpose** ____ **School**
____ **Insurance** _____ **Social Security/Disability Benefits**
____ **Other: Please explain** _____
Hospital Request: _____
(If a hospital Request the patient must receive a copy of the authorization)

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. I understand that this authorization will expire **60 days** from the date of this authorization unless I otherwise specify. I desire this authorization **to** be in effect until _____
Expiration event/date

I hereby release Seton Shoal Creek Hospital from all legal responsibilities or liability that may arise from disclosure of my medical records in reliance of this Authorization.

I understand that I may revoke this Authorization by requesting a written revocation of authorization form that can be obtained by calling/writing: ***3501 Mills Avenue, Austin Texas 78731, (512)324-2000***. I also understand that the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Date **Patient Signature**

Date **Parent/Guardian Signature**

Date **Staff Member Witness Signature**

Print Last Name