Kalin D. Kelso, M.D.
2200 Park Bend Drive, Suite 301
Austin, TX 78758
512-339-0440
512-339-0454 (fax)

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION (PLEASE PRINT CLEARLY)

Patient Name ______________________________ Phone Number ______________

Address ____
Street City State/Zip

Date of Birth ______________________ Social Security Number ______________

Authorizes (Name of Person/Facility) ____

Address ____
Street City State/Zip

Phone Number ______________________ Fax Number ______________________

To release the following information to:

KALIN D. KELSO, M.D.
AUSTIN ORTHOPEDICS AND SPORTS MEDICINE
2200 PARK BEND DRIVE, SUITE 301
AUSTIN, TX 78758

Please check patient records that may be released: ☐ All or specify below:

☐ Progress notes	☐ Physical	☐ X-ray, MRI, CT scan reports
☐ History Report	☐ Ultrasound	☐ Care/Treatment plan
☐ Pathology / lab reports	☐ Therapy	☐ Specialist letter/reports
☐ Operative reports	☐ Previous physician records	☐ Alcohol/drug use

Other (please specify) ____

This authorization covers patient care given from ________________ to ________________
Date Date

I understand that my records are protected by law and cannot be disclosed without this written consent unless otherwise provided in federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken on it (i.e., information already disclosed) and that in any event this consent expires automatically as described below. My signature also means that I have read this form and/or have had it read to me.

This consent shall expire ninety (90) days after the date signed, or as otherwise specified my a date or event unless previously revoked by me.

Effective Date: ________________ Expiration Date: ______________

I agree that a photocopy of this authorization may be considered valid: ☐ Yes ☐ No

Patient Signature: ________________________________ Date: ________________

Signature of legal guardian / parent if patient is minor/ child: ______________________