

One mailing address for all facilities (not a physical address):

Memorial Hermann Release of Information
7737 SWF C94 Houston, TX 77074

Authorization for: Disclosure Inspection Amendment Of Protected Health Information

Patient Name	Date of Birth	Medical Records#
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Address	Telephone # ()
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I hereby authorize Memorial Hermann Health System to release my records from the following facilities
(please check ONLY facilities that apply):

HOSPITALS:

- | | | | | |
|--|---|------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Memorial City | <input type="checkbox"/> NW/Greater Heights | <input type="checkbox"/> Southwest | <input type="checkbox"/> Northeast | <input type="checkbox"/> Sugar Land |
| <input type="checkbox"/> Hermann-TMC | <input type="checkbox"/> Katy | <input type="checkbox"/> Woodlands | <input type="checkbox"/> Southeast | <input type="checkbox"/> TIRR |
| <input type="checkbox"/> MHOSH | <input type="checkbox"/> Cypress | <input type="checkbox"/> Pearland | <input type="checkbox"/> Katy Rehab | |

OUTPATIENT CENTERS:

- | | | | | |
|-------------------------------------|--|--|--|--|
| <input type="checkbox"/> River Oaks | <input type="checkbox"/> Outpatient Imaging Center | <input type="checkbox"/> Sport Medicine/Physical Therapy | <input type="checkbox"/> Medical Group | |
| <input type="checkbox"/> Katy | <input type="checkbox"/> Convenient Care Center | <input type="checkbox"/> PhyTex/Mischer Assoc. | <input type="checkbox"/> Home Health | <input type="checkbox"/> Physicians at Sugar Creek |

RELEASE TO: Please provide Name/Address of person/organization to which disclosure is to be made

Phone # _____ Fax# _____

DATES OF SERVICE to be released: _____

Specify dates - this line **MUST BE** completed

For the following purpose: Medical Care Legal Insurance Other (detail below)

COPY MY MEDICAL RECORDS TO: please check one PAPER OR Electronic Disclosure such as CD

Select Portions of Protected Health Information MHHS is authorized to release

- | | |
|---|--|
| <input type="checkbox"/> Abstract/Pertinent Information | <input type="checkbox"/> ENTIRE RECORD INCLUDING - HIV TESTING ONLY |
| <input type="checkbox"/> Lab | <input type="checkbox"/> EXCLUSIONS |
| <input type="checkbox"/> Emergency Room | |
| <input type="checkbox"/> Radiology Reports | |
| <input type="checkbox"/> Admit/Discharge Summary | |
| <input type="checkbox"/> MD Progress Notes | _____ |
| <input type="checkbox"/> H&P | _____ |
| <input type="checkbox"/> Cardiac Studies | <input type="checkbox"/> Radiology Digital Images |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Itemized Bill |
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> CPT Codes |
| <input type="checkbox"/> Operative/Procedure Report | <input type="checkbox"/> Other _____ |

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of Memorial Hermann Health System 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.

_____	_____	_____	_____	_____	AM PM
Patient / Guardian Signature	Print Name	Relationship to patient	Date	Time	

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



Release of Protected Health Information

