MEMORIAL HERMANN

Patient Request To Have Medical Records Transferred To Another Health Care Provider

Patient Name: _____ **Date of Birth:** _____

Address: _____

Phone Number: _____

I am writing to request copies of my medical records from Memorial Hermann Health System.

My treatment dates are from: _____ **to:** _____

Fax my records to:

Name of provider: _____

Fax Number: _____ **Phone Number:** _____

Send the following items:

- ☐ Abstract of medical record
- ☐ Emergency Room
- ☐ Imaging/Radiology Reports
- ☐ Operative/Procedure Report
- ☐ Lab results
- ☐ Cardiac Studies
- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Other _____

The Release of Information Department does not process requests for imaging studies. Please call (713) 778-2545 for these requests.

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

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66987 (1/22)