Patient Right To Access Request For Medical Records

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email Address: _____

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

My treatment dates are from: _____ to: _____

Release Format (please select one):

☐ Paper (will be mailed to address above) ☐ CD (will be mailed to address above) ☐ Portal Download

☐ Fax Number: _____ ☐ Email Address: _____

Items to be sent to me:

☐ Complete Medical Record	☐ Emergency Room	☐ Radiology Reports
☐ Abstract/Pertinent	☐ History & Physical	☐ Cardiac Studies
☐ Operative/Procedure Report	☐ Lab	☐ Consultation Reports
☐ Discharge Summary	☐ Coding summary	☐ Other:_____

I understand that the following applicable fees will be charged for the production of the records, but I will not be charged for time spent locating the records:

- Email, Fax or Portal Download: $6.50
- CD: $6.50 plus USPS Priority Flat Rate shipping
- Paper (if total pages is less than 1000): $6.50 plus USPS Priority Flat Rate shipping
- Paper (if total pages is greater than 1000): Cost based fee of $.0067 per page plus USPS Priority Flat Rate shipping

To submit this form via mail, please address to:

Memorial Hermann Release of Information Department
7737 SW Freeway C94
Houston, Texas 77074

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

MEMORIAL HERMANN

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66989 (1/22)

Changes submitted on or before 1-18-22