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#
Address		**Telephone #** ( )

I hereby authorize Memorial Hermann Health System to release my records from the following facilities (please check ONLY facilities that apply):

HOSPITALS:

☐ **Memorial City**	☐ **NW/Greater Heights**	☐ **Southwest**	☐ **Northeast**	☐ **Sugar Land**
☐ **Hermann-TMC**	☐ **Katy**	☐ **Woodlands**	☐ **Southeast**	☐ **TIRR**
☐ **MHOSH**	☐ **Cypress**	☐ **Pearland**	☐ **Katy Rehab**	

OUTPATIENT CENTERS:

☐ **River Oaks**	☐ **Outpatient Imaging Center**	☐ **Sport Medicine/Physical Therapy**	☐ **Medical Group**	
☐ **Katy**	☐ **Convenient Care Center**	☐ **PhyTex/Mischer Assoc.**	☐ **Home Health**	☐ **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

☐ Abstract/Pertinent Information
☐ Lab
☐ Emergency Room
☐ Radiology Reports
☐ Admit/Discharge Summary
☐ MD Progress Notes
☐ H&P
☐ Cardiac Studies
☐ Consultation Report
☐ Face Sheet
☐ Operative/Procedure Report

☐ ***ENTIRE RECORD INCLUDING - HIV TESTING ONLY***

☐ ***EXCLUSIONS***

_____

_____

☐ Radiology Digital Images
☐ Itemized Bill
☐ CPT Codes
☐ 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 extend 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 In formation.

Date	**Signature of Patient/Parent/Conservator/Guardian**	**Authority/Relationship to Patients**

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.

MEMORIAL HERMANN

Release of Protected Health Information