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	SS#	Medical Records#
Address			Telephone # ( )

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

HOSPITALS:

❑ **Memorial City** 921 Gessner Rd PH 713-242-3401	❑ **Northwest** 1635 N. Loop West PH 713-867-4335	❑ **Southwest** 7600 Beechnut PH 713-456-5576	❑ **Northeast** 18951 Memorial N. PH 281-540-7971	❑ **Sugar Land** 17500 W. Grand Parkway South PH 281-725-5220
❑ **Hermann-TMC** 6411 Fannin PH 713-704-2162	❑ **Katy** 23900 Katy Fwy PH 281-644-7274	❑ **Woodlands** 9250 Pinecroft PH 713-897-2374	❑ **Southeast** 11800 Astoria Blvd PH 281-929-6170	❑ **TIRR** 1333 Moursund PH 713-799-7070

OUTPATIENT CENTERS: ❑ **River Oaks** ❑ **Outpatient Imaging Centers** ❑ **Sports Medicine/Physical Therapy**

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

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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)

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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
- ❑ Imaging/Radiology
- ❑ Admit/Discharge Summary
- ❑ H & P
- ❑ Cardiac Studies
- ❑ MD Progress Notes
- ❑ Consultation Report
- ❑ Face Sheet
- ❑ Operative/Procedure Report

- ❑ Entire Record ***EXCLUDING*** - HIV Testing & Chemical Dependency.
- ❑ Entire Record ***INCLUDING*** - HIV Testing & Chemical Dependency.
- ❑ Entire Record ***INCLUDING*** - HIV Testing only.
- ❑ Entire Record ***INCLUDING*** - Chemical Dependency only.
- ❑ 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 Healthcare 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.

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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.

Release of Protected Health Information

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