

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 Record#
Address			Telephone # ( )

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

**HOSPITALS:**

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> <b>Memorial City</b><br>921 Gessner Rd<br>PH 713-242-3401 | <input type="checkbox"/> <b>Northwest</b><br>1635 N. Loop West<br>PH 713-867-4335 | <input type="checkbox"/> <b>Southwest</b><br>7600 Beechnut<br>PH 713-456-5576  | <input type="checkbox"/> <b>Northeast</b><br>18951 Memorial N.<br>PH 281-540-7971  | <input type="checkbox"/> <b>Sugarland</b><br>17500 W. Grand Parkway South<br>PH 281-725-5220 |
| <input type="checkbox"/> <b>Hermann-TMC</b><br>6411 Fannin<br>PH 713-704-2162      | <input type="checkbox"/> <b>Katy</b><br>23900 Katy Fwy<br>PH 281-644-7274         | <input type="checkbox"/> <b>Woodlands</b><br>9250 Pinecroft<br>PH 281-364-2374 | <input type="checkbox"/> <b>Southeast</b><br>11800 Astoria Blvd<br>PH 281-929-6170 | <input type="checkbox"/> <b>TIRR</b><br>1333 Moursund<br>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

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

**DATES OF SERVICE to be released:** \_\_\_\_\_  
Specify dates – this line **MUST BE** completed

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

**COPY MY MEDICAL RECORDS TO:** please check one  PAPER OR  CD

**Select Portions of Protected Health Information MHHS is authorized to release:**

- |   |  |
|---|--|
| <input type="checkbox"/> Abstract/Pertinent Information | <input type="checkbox"/> Entire Record <b>EXCLUDING</b> - HIV Testing & Chemical Dependency. |
| <input type="checkbox"/> Lab                            | <input type="checkbox"/> Entire Record <b>INCLUDING</b> - HIV Testing & Chemical Dependency. |
| <input type="checkbox"/> Emergency Room                 | <input type="checkbox"/> Entire Record <b>INCLUDING</b> - HIV Testing only.                  |
| <input type="checkbox"/> Imaging/Radiology              | <input type="checkbox"/> Entire Record <b>INCLUDING</b> – Chemical Dependency only.          |
| <input type="checkbox"/> Admit/Discharge Summary        | <input type="checkbox"/> Itemized Bill   |
| <input type="checkbox"/> H & P                          | <input type="checkbox"/> CPT Codes   |
| <input type="checkbox"/> Cardiac Studies                | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> MD Progress Notes              |  |
| <input type="checkbox"/> Consultation Report            |  |
| <input type="checkbox"/> Face Sheet                     |  |
| <input type="checkbox"/> Operative/Procedure Report     |  |

**This authorization is valid until the 180<sup>th</sup> 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.

\_\_\_\_\_  
Date Signature of Patient/Parent/Conservator/Guardian Authority/Relationship to Patient

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. Email questions to [releaseofinformation@memorialhermann.org](mailto:releaseofinformation@memorialhermann.org)