MAILING ADDRESS: Memorial Hermann Release of Information 7737 SWF C94 Houston, TX 77074 (not a physical address)

MEMORIAL HERMANN Prevention & Recovery Center

Authorization for: ☐ Disclosure ☐ Inspection ☐ Amendment of Protected Health Information

Patient Name	Date of Birth	SS#	Medical Record #
Address			Telephone # ( )

Prohibition on Re-Disclosure of Protected Health Information Concerning Patient in Alcohol/Drug Abuse or Mental Health Treatment Program

I understand that my records are protected under the Federal regulations governing confidentiality of Alcohol and Drug Abuse or Mental Health Patient Records, 42 CFR Part 2, and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. This Notice accompanies a disclosure of information concerning a patient in alcohol/drug abuse or mental health treatment, made to you with the authorization of such patient. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written authorization of the person to whom it pertains or as otherwise by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby authorize **Memorial Hermann Prevention and Recovery Center** to release my Protected Health Information to the following**:**

TO:_____

_____

PHONE#_____ **FAX#**_____

DATES OF SERVICE TO BE RELEASED:_____

Specify dates- this lines **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:

☐ Abstract/Pertinent Information	☐ Entire Record ***EXCLUDING*** - HIV Testing & Chemical Dependency.
☐ Lab	
☐ Emergency Room	☐ Entire Record ***INCLUDING*** - HIV Testing & Chemical Dependency.
☐ Imaging/Radiology	
☐ Admit/Discharge Summary	☐ Entire Record ***INCLUDING*** - HIV Testing only.
☐ H & P	
☐ Cardiac Studies	☐ Entire Record ***INCLUDING*** – Chemical Dependency only.
☐ MD Progress Notes	
☐ Consultation Report	☐ Itemized Bill
☐ Face Sheet	
☐ Operative/Procedure Report	☐ 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.

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**