HOUSTON Methodist LEADING MEDICINE

Medical Records Release of Information

Date of Request: ______________

Requestor Information

☐ Current Employee ☐ Current Volunteer ☐ Former Employee or Volunteer ☐ Other Job Title/Department (Physician, Allied Health etc.)

Given Name: ______________________________ Date of Birth: _______________________

Employee ID#: ______________________ **OR** Last 5 numbers of SS# ___-_________

Phone#: __________________________ Work#: _________________________________

I, _____________________________, hereby give Houston Methodist Employee Health Department written authorization to release the following Employee Medical Records: (please check all that apply)

☐ TB Test ☐ Immunizations ☐ Respirator Fit Test

☐ X-Rays ☐ Laboratory Reports ☐ Other__________________

Please send records via: (Please check ONE)

I understand that I have the right to receive my health information in the form and format of my preference to the extent my information is held in electronic form and Houston Methodist is capable of fulfilling the request. I also understand that I may request my information to be sent via unencrypted email or to my unsecure email account. By choosing that type of format, I accept the fact that my information may be at risk of being read or accessed by someone else. Initial_______

☐ Will pick up at Employee Health Clinic ***(MUST be within 1 month of request date or new request will need to be submitted)***

OR

☐ Secure email (**ONLY** Houston Methodist email address):_______________________________

OR

☐ Other email address (unsecure): ____

Print Name: __________________________Signature: _______________________________

Date: __________________

Date Released: _______________________ Released by Signature: _______________________

*Please submit to your primary work location

***Please allow 2 business days for records to be prepared ***