

Name: _____



Date of Birth: _____ Social Security# (last 4 digits): _____

002351

Mailing Address: _____

Telephone Number: _____ Alternate Telephone Number: _____

I hereby authorize Houston Methodist at:

- Medical Center Campus • 6565 Fannin Street, ST-520 • Houston, TX 77030 • Phone: 713.441.2401 • Fax: 713.441.0095
- Baytown Campus • 4401 Garth Road • Baytown, TX 77521 • Phone: 281.420.8760 • Fax: 281.428.4543
- Continuing Care Campus • 701 S. Fry Road • Katy, TX 77450 • Phone: 832.522.7285 • Fax: 832.522.7756
- Clear Lake Campus • 18300 St. John Drive • Nassau Bay, TX 77058 • Phone: 281.333.8832 • Fax: 281.333.8872
- Sugar Land Campus • 16655 SW Fwy, MOB 2, Suite 529 • Sugar Land, TX 77479 • Phone: 281.274.7814 • Fax: 281.274.8300
- West Campus • 18500 Katy Freeway • Houston, TX 77094 • Phone: 832.522.3040 • Fax: 832.522.3041
- Willowbrook Campus • 18220 State Highway 249 • Houston, TX 77070 • Phone: 281.737.1602 • Fax: 281.737.1616
- The Woodlands Campus • 17183 I-45 South, Suite 150 • The Woodlands, TX 77385 • Phone: 936.270.2191 • Fax: 936.270.2730

To disclose/release the specified information below: **To receive** the specified information below:

To: _____ From: _____

Telephone Number: _____ Telephone Number: _____
 Fax Number: _____ Fax Number: _____

Health Information to be disclosed (please check below):

Date(s) of Service: _____

- | | | | |
|---|---|---|------------------------------------|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Pictures* |
| <input type="checkbox"/> Operative/Procedure Report | <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Films* |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Pathology Slides/Blocks* | <input type="checkbox"/> ER Record | |
| <input type="checkbox"/> Other (specify) _____ | | | |

*Please note: The Health Information Management Department may not be responsible for films, pictures, and/or pathology slides/blocks. To obtain these, please send the completed authorization form to the department that performed your tests.

Purpose of Disclosure: Continuum of care or Other (specify): _____

I hereby authorize the use or disclosure of my health information as described above. I understand the information used or disclosed may include information relating to Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), sexually transmitted diseases, behavioral or mental health services, and/or treatment for alcohol and drug abuse. This authorization is valid for 180 days unless specified otherwise here: _____

I understand I may cancel this request at any time by written notification to the disclosing facility noted above unless the disclosure process has already occurred. I understand the information used or disclosed may no longer be protected by federal regulations and thus subject to re-disclosure by the recipient. I understand that treatment or payment may not be conditioned upon my completion of this form. I understand I will be asked to provide proof of my identity and/or guardianship (if applicable) with this authorization. A photocopy or fax of this authorization form is as valid as the original. Fees/charges for obtaining copies of records will comply with all applicable state laws and regulations. I understand that Houston Methodist may disclose my Protected Health Information electronically or by other means. Payment is due either before or at the time of disclosure.

Signature of Patient or Personal Representative

Date

Printed Name of Personal Representative (if applicable)

Relationship to Patient (Parent, Guardian, etc)



**AUTHORIZATION FOR USE AND
 DISCLOSURE OF HEALTH
 INFORMATION**
 FORM # 2351 (09/2018) - Version 2
 HIM

