AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

HM2175

Patient Name (Print): _____

Date of Birth: _____ Social Security Number (last 4 digits): X X X - X X - _____

Patient's Mailing Address: _____

_____

Primary Contact Number: _____

I hereby request access to my records held by _____

[Name of Houston Methodist Physician Office or Hospital]

Purpose of release: ☐ Continuum of care **or** ☐ Other (specify):_____

Protected Health Information (PHI) to be released (please check below):

Date(s) of service: _____

☐ Complete Medical Record	☐ History and Physical(s)	☐ Discharge Summary	☐ Consultation Report
☐ Operative/Procedure Report	☐ Lab Results	☐ Radiology Reports	☐ Radiology Films
☐ Clinic Progress Notes	☐ ER Record	☐ Other _____	
	☐ Pictures*	☐ Pathology Slide/Blocks*	

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

I understand that information released pursuant to this request may include information relating to Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

Form and format of the release:

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.**

Preferred form and format: ☐ Password Protected CD *[Default]* ☐ Secured E-mail ☐ Paper

☐ HM MyChart Patient Portal ☐ Unsecured E-mail ☐ Other _____

Designated individual to receive the records: ☐ Self **or** ☐ Other Designated Individual

Fees/charges for obtaining copies of records will comply with all applicable state laws and federal regulations. I understand that Houston Methodist may release my Protected Health Information electronically or by other means. Payment is due either before or at the time of release.

CONTACT INFORMATION FOR RECIPIENT: *(Full address, FAX number **or** E-mail address)*	**FOR OFFICE USE:**
	☐ Scribed/documented by HM Staff Member: _____ [Original patient request made on alternate form. (See attached.)]

I authorize the release of health information as described above.

_____ _____

Signature of Patient or Qualified Personal Representative * **Date/Time**

* If signed by a Qualified Personal Representative, the following must be completed:

Printed name of Qualified Personal Representative: _____

Legal Authority to Act on Behalf of the Patient: _____

[Example: Parent, Guardian, Executer of Estate]

ADHERE PATIENT LABEL WITHIN THIS AREA

HOUSTON Methodist LEADING MEDICINE

PATIENT ACCESS
REQUEST FOR MEDICAL RECORDS

FORM# HM2175 (01/2017) - Version 2
HIM