002351

Name: _____

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

Mailing Address: _____

Telephone Number: _____ Alternate Telephone Number: _____

I hereby authorize:

☐ Houston Methodist Hospital • 6565 Fannin Street, ST-520 • Houston, TX 77030 (Fax: 713.441.0095)
☐ Houston Methodist San Jacinto Hospital • 4401 Garth Road • Baytown, TX 77521 (Fax: 281.428.4543)
☐ Houston Methodist St. Catherine Hospital • 701 South Fry Road • Katy, TX 77450 (Fax: 281.599.6866)
☐ Houston Methodist St. John Hospital • 18300 St. John Drive • Nassau Bay, TX 77058 (Fax: 281.333.8872)
☐ Houston Methodist Sugar Land Hospital • 16655 Southwest Freeway • Sugar Land, TX 77479 (Fax: 281.274.8300)
☐ Houston Methodist West Hospital • 18500 Katy Freeway • Houston, TX 77094 (Fax: 832.522.3041)
☐ Houston Methodist Willowbrook Hospital • 18220 Tomball Parkway • Houston, TX 77070 (Fax: 281.737.1616)

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

To: _____

_____

_____

Telephone Number: _____

Fax Number: _____

☐ **To receive** the specified information below:

From: _____

_____

_____

Telephone Number: _____

Fax Number: _____

Health Information to be disclosed (please check below):

Date(s) of Service: _____

☐ Complete Medical Record
☐ Operative/Procedure Report
☐ History and Physical
☐ Other (specify) _____
☐ Discharge Summary
☐ Consultation Report
☐ Pathology Slides/Blocks*
☐ Radiology Reports
☐ Laboratory Results
☐ ER Record
☐ Pictures*
☐ Films*

**Please note: The Health Information Management Department is not 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)

ADHERE PATIENT LABEL WITHIN THIS AREA

HOUSTON Methodist® LEADING MEDICINE

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND PATIENT ACCESS/COPY REQUEST

White - Facility copy Yellow - Patient copy FORM # 2351 (03/2015)