

**Memorial Hermann Healthcare System**

Authorization for:     Disclosure             Inspection             Amendment  
**Of Protected Health Information**

Patient Name	Date of Birth	SS#	MR#
Address			Telephone # (        )
I hereby authorize _____ <div style="text-align: center;"><i>Facility Name</i></div>			
To release information from the medical records of _____ <div style="text-align: center;"><b>Patient Name</b></div>			
To: _____ <div style="text-align: center;"><b>Name/Address of person/organization to which disclosure is to be made</b></div>			
Fax # _____		Phone # _____	
For treatment dates: _____ <div style="text-align: center;">Specify dates -- this line <b>MUST BE</b> completed</div>			
For the following purpose: <input type="checkbox"/> Medical Care <input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> Other (detail below)			
<b>Select Portions</b>			
<input type="checkbox"/> Abstract/Pertinent Information <input type="checkbox"/> Lab <input type="checkbox"/> Emergency Room <input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Nursing Notes <input type="checkbox"/> H & P <input type="checkbox"/> Cardiac Studies <input type="checkbox"/> MD Progress Notes <input type="checkbox"/> MD Orders <input type="checkbox"/> Face Sheet <input type="checkbox"/> Operative/Procedure Report		<input type="checkbox"/> Entire Record <b><u>EXCLUDING</u></b> - HIV Testing & Chemical Dependency. <input type="checkbox"/> Entire Record <b><u>INCLUDING</u></b> - HIV Testing & Chemical Dependency. <input type="checkbox"/> Entire Record <b><u>INCLUDING</u></b> - HIV Testing only. <input type="checkbox"/> Entire Record <b><u>INCLUDING</u></b> – Chemical Dependency only. <input type="checkbox"/> Itemized Bill <input type="checkbox"/> Other _____	
<b>This authorization is valid until the 180<sup>th</sup> 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.</b>			
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 <i>Patient</i>		_____ Authority/Relationship to

Fees/charges will comply with all laws and regulations applicable to release of Protected Health Information  
 Payment is due at time of release.