002351

Name: _____

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

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, MOB 2, Suite 225 • The Woodlands, TX 77385 • Phone: 936.270.2191 • Fax: 936.270.2730

☐ **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 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)

ADHERE PATIENT LABEL WITHIN THIS AREA

HOUSTON Methodist® LEADING MEDICINE

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

FORM # 2351 (03/2019) - Version 3
HIM