EAST HOUSTON
MEDICAL CENTER
15149 Wallisville Rd
Houston, TX, 77049
Phone: 832-400-2396 Fax: 832-400-2397

MEDICAL RECORDS REQUEST FORM

This form is used to request copies of medical records. Only patients or their legal representatives may make a medical record request. East Houston Medical Center may verify your identity. Some requests may be subject to a reasonable fee.

PATIENT INFORMATION

Name: _____ Date of Birth (MM/DD/YYYY): _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

WHAT INFORMATION ARE YOU REQUESTING DISCLOSURE:

- ☐ Discharge Summary
- ☐ History/Physical
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Consultation Reports
- ☐ Itemized Billing
- ☐ Other: _____
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Progress Notes
- ☐ Past/Present Medications
- ☐ Patient Information
- ☐ Entire Medical Record

Date(s) of Service: _____ to _____

PURPOSE OF DISCLOSURE:

- ☐ Personal Use (Skip to "Medium of Delivery")
- ☐ Treatment/Continuing Medical Care
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

INFORMATION TO BE DISCLOSED TO OR OBTAINED FROM:

(If the disclosure is for personal use, skip this section)

I want the requested medical records to be sent to or obtained from the third party I have indicated below. My completion of this form serves as my authorization for East Houston Medical Center to disclose to or obtain these records from this person or group. I understand that once my information leaves East Houston Medical Center, East Houston Medical Center is no longer able to protect the information, and the recipients of my information may not be legally required to protect my information.

Name: _____ Phone: _____ Fax: _____

Mailing Address: _____

Name: _____ Phone: _____ Fax: _____

Mailing Address: _____

MEDIUM OF DELIVERY:

☐ Paper ____ Pick up >or< ____ mail to address listed above

☐ Electronic Form of: ____ Fax #: _____

____ Secure email (must be private email address): _____

TERMS OF AUTHORIZATION

I, the undersigned, have read the above and authorize the staff of East Houston Medical Center to disclose such information as herein contained. I may refuse to sign this authorization and that it is strictly voluntary. 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 East Houston Medical Center, its employees, officers, staff, and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information. East Houston Medical Center will not condition treatment, payment, enrollment or eligibility for benefits on my completion of this form. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee. Unless otherwise revoked, this authorization will expire on the sooner of 12 months from the date of this authorization or on the date it is revoked.

Signature: _____ Date: _____

Printed Name: _____

Authority/Relationship to Patient: _____

AFFIX PATIENT LABEL HERE