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 _____
Facility Name

To release information from the medical records of _____
Patient Name

To: Ross Reporting Services, 11706 Playa Court, Houston, Texas 77034
Name/Address of person/organization to which disclosure is to be made

Fax # (281) 484-1140 Phone # (281) 484-0770

For treatment dates: _____
Specify dates – this line **MUST BE** completed

For the following purpose: ☐ Medical Care ☐ Legal ☐ Insurance ☐ Other (detail below)

Select Portions

☐ Abstract/Pertinent Information
☐ Lab
☐ Emergency Room
☐ Imaging/Radiology
☐ Nursing Notes
☐ H & P
☐ Cardiac Studies
☐ MD Progress Notes
☐ MD Orders
☐ Face Sheet
☐ Operative/Procedure Report

☐ Entire Record ***EXCLUDING*** - HIV Testing & Chemical Dependency.
☐ Entire Record ***INCLUDING*** - HIV Testing & Chemical Dependency.
☐ Entire Record ***INCLUDING*** - HIV Testing only.
☐ Entire Record ***INCLUDING*** – Chemical Dependency only.
☐ Itemized Bill
☐ Other _____

This authorization is valid until the 180th 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.

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** **Authority/Relationship to**
Patient

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