Name: _____

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

Mailing Address: _____

Telephone Number: _____ Alternate Telephone Number: _____

002351

I hereby authorize:

( ) The Methodist Hospital
6565 Fannin Street
Houston, TX 77030

( ) San Jacinto Methodist Hospital
4401 Garth Road
Baytown, TX 77521

( ) Methodist Sugar Land Hospital
16655 Southwest Freeway
Sugar Land, TX 77479

( ) Methodist Willowbrook Hospital
18220 Tomball Parkway
Houston, TX 77070

( ) Methodist West Houston Hospital
18500 Katy Freeway
Houston, TX 77094

( ) **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 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

Methodist The Methodist Hospital System

FORM # 2351 (10/2012)

Authorization For Use And Disclosure Of Health Information And Patient Access