MEMORIAL HERMANN

Patient Right To Access Request For Medical Records

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

I am writing to request copies of my medical records from Memorial Hermann Health System.

My treatment dates are from: _____ to: _____

Format for release (please select one):

☐ Paper (will be mailed to address above) ☐ CD (will be mailed to address above)

☐ Fax to me: _____ ☐ Email to me: _____

Items to be sent to me:

☐ Complete Medical Record	☐ Emergency Room	☐ Radiology Reports
☐ Abstract/Pertinent	☐ History & Physical	☐ Cardiac Studies
☐ Operative/Procedure Report	☐ Lab	☐ Consultation Reports
☐ Discharge Summary	☐ Coding summary	☐ Other: _____

I understand that I will be charged $6.50 for the production of the records, but that I will not be charged for time spent locating the records. If requesting paper copies, I will be charged USPS Priority flat rate for shipping.

_____	_____	_____
Date	Signature	Relationship

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66989 (6/16)