One mailing address for all facilities (not a physical address):
Memorial Hermann Release of Information
7737 SWF C94 Houston. TX 77074

Authorization for: ☐ Disclosure ☐ Inspection ☐ Amendment Of Protected Health Information

Patient Name	Date of Birth	Medical Records#
Address		Telephone # ( )

Prohibition on Re-Disclosure of Protected Health Information Concerning Patient in Alcohol/Drug Abuse or Mental Health Treatment Program

I understand that my records are protected under the Federal regulations governing confidentiality of Alcohol and Drug Abuse or Mental Health Patient Records. 42 CFR Part 2, and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. This Notice accompanies a disclosure of information concerning a patient in alcohol/drug abuse or mental health treatment, made to you with the authorization of such patient. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for the purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby authorize (Facility Name) _____
Facility Name

To release information from the medical records of _____
Patient Name

To: _____
Name/Address of person/organization to which disclosure is to be made

Fax # _____ Phone # _____

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

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

COPY MY MEDICAL RECORDS TO: please check one ☐ PAPER OR ☐ Electronic format (CD)

Select Portions of Protected Health Information MHHS is authorized to release

☐ Abstract/Pertinent Information
☐ **L**ab
☐ Emergency Room
☐ Radiology Reports
☐ Admit/Discharge Summary
☐ MD Progress Notes
☐ H&P
☐ Cardiac Studies
☐ Consultation Report
☐ Face Sheet
☐ Operative/Procedure Report

☐ Entire Record ***INCLUDING*** - HIV

☐ ***EXCLUSIONS***
_____
_____

☐ Itemized Bill
☐ CPT Codes / Coding Summary
☐ 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 Health 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 Patients

Fees/charges will comply with all laws and regulations applicable to release of Protected Health Information. Records will be released after full payment has been received.

MEMORIAL HERMANN

Release of Protected Health Information

ALCOHOL, DRUG ABUSE OR MENTAL HEALTH TREATMENT PROGRAM

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