

Patient Right To Access Request For Medical Records

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email Address: _____

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

My treatment dates are from: _____ to: _____

Release Format (please select one):

- Paper (will be mailed to address above) CD (will be mailed to address above) Portal Download
 Fax Number: _____ Email Address: _____

Items to be sent to me:

- | | | |
|---|---|---|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Abstract/Pertinent | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Cardiac Studies |
| <input type="checkbox"/> Operative/Procedure Report | <input type="checkbox"/> Lab | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Coding summary | <input type="checkbox"/> Other: _____ |

I understand that the following applicable fees will be charged for the production of the records, but I will not be charged for time spent locating the records:

- Email, Fax or Portal Download: \$6.50
- CD: \$6.50 plus USPS Priority Flat Rate shipping
- Paper (if total pages is less than 1000): \$6.50 plus USPS Priority Flat Rate shipping
- Paper (if total pages is greater than 1000): Cost based fee of \$.0067 per page plus USPS Priority Flat Rate shipping

Patient / Guardian Signature

Print Name

Relationship to patient

Date

**MEMORIAL
HERMANN**
**Patient Right To
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