Medical Records Request Form

This form is used to request copies of medical records. Only patients or their legal representatives may make a medical record request. Texas Children's may verify your identity/guardianship. Some requests may be subject to a reasonable fee. You can request an electronic PDF copy of medical records via your MyChart Patient Portal. Please print.

Part 1: Patient Information

Patient Name (please print): _____ Date of birth (MM/DD/YYYY): _____

Address: _____Contact Phone: _____

City: _____ State: _____ ZIP: _____

Part 2: Protected Health Information that you are requesting to be released:

Information to be released for the date(s) of service from (date) _____ to (date) _____

Type of Information to be released: **Please do not check every box if complete record is needed; see first box.**

☐ Complete health record	☐ Discharge Summary	☐ Radiology Reports	☐ Billing (Claim information)
☐ Inpatient Abstract	☐ ER Record	☐ EKG/Cardiology Reports	☐ Radiology Images on CD
☐ Clinic/Outpatient Visit Specify visit date: _____ Specify Provider: _____	☐ Consultation Reports	☐ Pathology Reports	☐ Photographs/Digital or other images/Video Specify: _____
☐ History/Physical	☐ Operative/Procedure Reports	☐ Lab Results	☐ Other: _____

Part 3: SPECIFIC AUTHORIZATION, which requires specific consent under federal law: (check all that apply)

☐ Psychiatric/mental health records ☐ Neuropsychological testing ☐Genetic health record/ testing

Mental/behavioral health records (may require physician/psychologist approval)

Part 4: Preferred Format: I understand I have the right to receive my health information in the format of my preference to the extent my information is held in electronic form and Texas Children's is capable of fulfilling the request.

☐ Password Protected CD ☐ Paper Copies Mailed ☐ Paper Copies to be picked up

☐ Electronic (PDF) MyChart Patient Portal (must be requested through your MyChart Portal)

Part 5: Purpose of Release: ☐ Continuum of Care ☐ Other (specify): _____

Part 6: If records are to be released to third-party. (If the disclosure is for personal use, skip this section.)

I want the requested medical records to be sent to the third-party (for example, an employer or a school) I have indicated below. My completion of this form serves as authorization for Texas Children's to disclose these records to this person or group. I understand that once my information leaves Texas Children's, Texas Children's is no longer able to protect the information, and the recipients of my information may not be legally required to protect my information.

Name of Individual you wish to receive the records: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Fax Number (if less than 50 pages of paper records): _____

Part 7: Terms of Authorization: I understand this authorization may be revoked in writing at any time, according to the instructions in Texas Children's Notice of Privacy Practices, except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the sooner of 180 days from the date of this authorization or on the date indicated here: _____.

All releases based on this form are limited to records dated up to and including the date of the patient/legal guardian's signature. A new release is necessary for release of information on care provided after the date of the patient/legal guardian's signature.

If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes. Texas Children's will not condition treatment or payment on my completion of this form.

Part 8: Signatures

Signature of Patient/Patient Legal Representative:	Date:
Printed Name of Patient's Legal Representative:	Relationship to Patient:

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, Tex. Fam. Code §32.003).

Minor Patient's Signature:_____Date:_____

Mail, fax, or deliver completed forms to:
Health Information Management - Release of Information,
MC A-1195 Texas Children's
6621 Fannin Street Houston, TX 77030
Fax: 832-825-9056 Email: releinfo@texaschildrens.org