Texas Children's

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. Please print.

Part 1: Patient Information Name:_____ Date of birth (MM/DD/YYYY): _____

Address:_____ Phone:_____

City:_____ State:_____ ZIP:_____

Part 2: What information are you requesting? (Mark all that apply)

Date(s) of service:_____

☐ Clinic/ Outpatient Record. Clinic:_____ Provider:_____

☐ Inpatient Abstract (includes face sheet, discharge summary, history and physical exam, operative and pathology reports, consultation reports, radiology reports and EEGs)

☐ Discharge Summary
☐ History/Physical Exam
☐ Operative Reports
☐ Pathology Reports
☐ Consultation Reports
☐ Radiology Reports & Images
☐ EKG/Cardiology Reports
☐ Lab Results
☐ Progress Notes
☐ Past/Present Medications
☐ Patient Allergies
☐ Billing (Claim) Information
☐ Other_____
☐ **All health information**

Mental/behavioral health records (may require physician/psychologist approval):
☐Psychiatric/mental health records ☐Neuropsychological testing ☐Other _____

Part 3: Purpose of Disclosure: (Please select only one box)

☐ Personal Use (Skip Part 4 below)
☐ Treatment/Continuing Medical Care
☐ Billing or Claims
☐ Insurance
☐ Legal Purposes
☐ Disability Determination
☐ School
☐ Employment
☐ Other _____

Part 4: To be completed only for third-party disclosures. (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:_____

Mailing Address:_____

Texas Children's Pediatrics
Town & Country @ West Campus
18200 Katy Frwy., Suite WA160
Houston, Texas 77094

Phone: 281-579-6414
FAX: 281-829-6538

Part 5:

☐ **Check here if you wish to have the records provided in electronic format (CD).** This is available only for records within Texas Children's electronic health record system.

Part 6: 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:_____. 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.

Signature:_____ Date: _____

Printed name:_____ 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's Signature:_____ Date:_____

Texas Children's Pediatrics
Town & Country At West Campus
18200 Katy Frwy Suite WA160
Houston, Texas 77094
281-579-6414 Fx: 281-829-6538