HOUSTON PHYSICIANS' HOSPITAL

# Request for Access to Health Information

**1. Who is the patient?**

Patient Name: _____ Date of Birth: _____

Street Address: _____ City, State & Zip _____

Last 4 Social Security Number: _____ Phone Number: _____

Email: _____

**2. What information do you need? Select all that apply.**

___ All Health Information ___ History and Physical Report ___ Radiology Report(s)

___ Consultation Report ___ Laboratory Result(s) ___ Operative Report

___ Emergency Room Record ___ Pathology Report ___ Discharge Summary

___ Other (specify) _____

**Date range for request: Records From (date) _____ to (date) _____**

**3. From which locations are you requesting information?**

___ Houston Physician's Hospital ___ Physical Therapy Location

___ All ___ Other (specify) _____

**4. How would you like to receive the records?**

___ Paper ___ Encrypted CD ___ Unencrypted CD (Please read below*)

___ Encrypted Email ___ Unencrypted Email (please read below*)

** Unencrypted email – Please read and initial acknowledgement and acceptance of the risk that this is an unsecure method of delivery and that the records may be intercepted while being sent.* _____

**5. How would you like to receive the records?**

___ Pickup in person by (Date): _____ ___ Mailed to patient's address listed above

___ Pickup by other individual (please specific)*_____

*(*Individual will be require to present photo ID)*

___ Mailed to other person/location. Name: _____

Address: _____

City, State, Zip _____

**6. REQUIRED: Please upload a legible copy of a valid photo I.D (e.g., driver's license, military I. D. or state I.D.): [Choose File]__**

**7. Please read and initial that you understand the important information below.**

*I understand that these records may contain reference to: alcohol/drug use or abuse, mental health information, HIV/AIDS tests, genetic information and sexually transmitted diseases.* _____ (initial)

Signature: _____ Date: _____

Relationship (if not patient): _____

Witness: _____