MEMORIAL HERMANN

Patient Request To Have Medical Records Transferred To Another Health Care Provider

Patient Name: _____ **Date of Birth:** _____

Address: _____

Phone Number: _____

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

My treatment dates are from: _____ **to:** _____

Fax my records to:

Name of provider: _____

Fax Number: _____ **Phone Number:** _____

Send the following items:

- ☐ **Abstract of medical record**
- ☐ **Emergency Room**
- ☐ **Imaging/Radiology Reports**
- ☐ **Operative/Procedure Report**
- ☐ **Lab results**
- ☐ **Cardiac Studies**
- ☐ **History and Physical**
- ☐ **Discharge Summary**
- ☐ **Other** _____

The Release of Information Department does not process requests for imaging studies. Please call (713) 778-2545 for these requests.

_____ _____

Date **Signature**

MEMORIAL HERMANN

Patient Request To Have Medical Records Transferred To Another Health Care Provider

66987 (2/19)