

**Patient Request for Access to Protected Health Information**

*This form must be submitted by patients to request inspection and/or copies of their protected health information.  
Please read the instruction page (attached) before completing this form.*

**I.** Patient name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Mailing address: \_\_\_\_\_ Home phone: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_ Dates of service: \_\_\_\_\_

**II.** I wish to (check one):  Inspect the record  Obtain copies of the record (fee schedule available in HIM Department)

**III.** I want to inspect or obtain copies of the following reports:

Abstract - includes face sheet, discharge summary, history and physical exam, operative and pathology reports, consultation reports, radiology reports and EEGs

Or:

Discharge summary

Operative reports

History and physical exam

Clinic/outpatient record

Consultation reports

Which clinic or doctor? \_\_\_\_\_

Progress notes

Billing claim forms

Radiology reports

Itemized statement of charges

Laboratory reports

Other, specify: \_\_\_\_\_

Pathology reports

All information

Or, for mental health records (may require physician/psychologist approval):

Psychiatric/mental health records

LSC/CAP records

Neuropsychological testing

Other, specify: \_\_\_\_\_

All information

Please note that currently Texas Children's Hospital can provide only paper copies for most reports.

**IV.** I request Texas Children's Hospital (Texas Children's) to provide me with access to the protected health information as described above. I understand the following:

- 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 reserves the right to verify my identity/guardianship.
- I will be charged for copies that I have requested.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**V.** Mail copies to (address): \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Or, if you wish to pick up the copies, give phone number to call: \_\_\_\_\_

**Mail or deliver completed form to:**

Release of Information, MC-A1195

Texas Children's Hospital

6621 Fannin Street

Houston, TX 77030

For more information, contact Texas Children's Health Information Management Department  
at 832/824-1634, -1651, or -1670 (Fax: 832/825-9056 or -0110)