INCOMING RECORDS REQUEST

HIPAA Privacy Authorization to Request Patient Records from Another Healthcare Provider

*Patient's Name: ___________________________________ *Date of Birth: _____________________ *Phone Number: ______________________

Previous Name: ___________________________

I Request and Authorize:

*Name/Facility: ____

*Phone Number: _________________________ *Fax Number: _________________________

To Release My Health Information To:

MyCHN
Administrative Office: MyCHN Pearland
1346 E. Broadway St., Ste 100
Pearland, TX 77581
Ph: 281-824-1480 Fax: 281-220-6442 Website: www.mychn.org

Information to be Released:

☐ Medical Records
☐ Mental Health (Counseling and Psychiatry)
☐ Dental Records
☐ Drug/Alcohol/Chemical Treatment Records
☐ Immunization Records
☐ Other ex.) ER Visits, Please Specify: ____

By signing this Authorization form, I understand that I am giving my authorization for MyCHN to receive all protected health information (PHI) relating to my diagnosis, testing or treatment. I understand that my expressed consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. I may revoke this authorization at any time by notifying MyCHN in writing to the Medical Records Department.

Patient or Guardian Signature: ___________________________________ Date: _________________________

Guardian Name: (if applicable) ____________________________________ Relationship to Patient: __________________________

THIS AUTHORIZATION MUST BE COMPLETED IN ITS ENTIRETY OR REQUEST WILL NOT BE PROCESSED.
This authorization automatically expires 6 months (180-days) from the date of signature.
Revised 9/23/2020, 8/8/2025