



OUTGOING MEDICAL RECORDS REQUEST

HIPAA Privacy Authorization to Release Patient Records

*Patient's Name:

*Date of Birth:

*Phone Number:

Previous Name: _____

I, Request and Authorize:

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

To Release Information to:

*Name/Facility: _____

*Address: _____

*Phone Number: _____

*Fax Number: _____

Information to be Released:

Medical Records

Dental Records

Mental Health (Counseling and Psychiatry)

Billing Records

Drug/Alcohol/Chemical Treatment Records

Immunization Records

*(*42 C.F.R Part 2 Release Required)*

Other ex.) ER Visits, Please Specify: _____

Sensitive Information to be Released:

By signing this Authorization form, I understand that I am giving my authorization for MyCHN to release 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:

DEADLINE FOR RELEASE OF RECORDS: THE REQUESTED COPIES OF MEDICAL AND/OR BILLING RECORDS OR A SUMMARY OR NARRATIVE OF THE RECORDS SHALL BE FURNISHED BY MYCHN WITHIN 10 BUSINESS DAYS AFTER THE DATE OF RECEIPT OF THE REQUEST.

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