Memorial Bone & Joint Clinic and Referred Service Providers

909 Frostwood, Suite # 251 Houston, TX 77024
909 Frostwood, Suite # 237 Houston, TX 77024
8830 Long Point Rd., Suite # 603 Houston, TX 77055
Phone: 713-827-9316 Fax: 713-827-8345

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____________________________ Date of Birth: ____________________________

Previous Name: ____________________________ Social Security #: ___________________________

I request and authorize **Memorial Bone & Joint Clinic** to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ______________________________ State: __________ Zip Code: ______________

Phone: _____________________________ Fax: ___________________________________

This request and authorization applies to:

Progress notes ☐	Pathology Reports ☐
Discharge Summary ☐	Laboratory Reports ☐
History & Physical ☐ Radiology Reports ☐	Human Immunodeficiency Virus (HIV) or (HIV) Acquired Immune Deficiency Syndrome ☐
Consultation Reports ☐	Diagnostic Reports ☐
Physician's Orders ☐	Mental Health Records ☐
Operative Reports ☐	Entire Medical Records ☐
Others: (please specify) ____	

For the purpose of:

Continuing Medical Care☐	Insurance ☐	Legal Purposes☐
Social Security/Disability☐	Personal Use☐	Others:
School☐	Military☐	

By signing and dating below, I realize that this authorization to release healthcare information will remain in effect until I notify Memorial Bone & Joint Clinic in writing of my request to revoke the authorization. I understand that once Memorial Bone & Joint Clinic receive my written request, my request to revoke authorization will become effective immediately.

I understand that this authorization will expire one year from the date it is signed.

____ ________________________

Signature of Patient or Legally Authorized Representative Date