MEDICAL CLINIC OF HOUSTON L.L.P.

1701 Sunset Boulevard
Houston, Texas 77005-1713
(713) 526-5511
(713) 526-0451 (FAX)

REQUEST TO VIEW MEDICAL RECORD

Please print all information, then sign and date this authorization form.

Patient Name _____ **DOB** _____ **MCH Account #** _____

Phone (Home) _____ **(Other)** _____

I request to view my medical record. I understand that my physician may be contacted for approval and may deny my access.

Upon your physician's approval, you may review the record at a mutually agreeable time on a weekday, Monday through Friday, from 9:00 a.m. to 3:00 p.m.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Printed Name (if other than patient)

Relationship Parent/Conservator/Guardian/Other _____

If the patient is unable to sign this request, please provide a Medical Power of Attorney, Declaration of Heirship, or a copy of the patient's Death Certificate if the patient is deceased.

FOR CLINIC USE ONLY

Physician or Health Care Provider Response

Signature of Physician _____ **Date** _____

Printed Name _____

Date scheduled to review medical record _____

Time scheduled to review medical record _____

Signature of Privacy Officer or Designee _____ **Date** _____

Printed Name _____