ST. MARY'S MEDICAL CENTER

Patient Name:	Date of Birth:	Patient's Phone:	Last 4 digit SSN (optional)

Provider's Name		Provider's Phone:
Provider's Address:		
Recipient's Name:		Recipient's Phone:
Recipient's Address:		

Request Delivery (If left blank, a paper copy will be provided): ☐ Paper Copy ☐ Electronic Media (CD/DVD)
☐ Other (provide details) _____
We are not responsible for unauthorized access to the PHI contained in electronic format after delivery to you.

Expiration: This authorization will expire **90 days** from this date unless the following is completed. (Fill in the Date or the Event but not both.)
Date: _____ Event: _____

Purpose of disclosure:

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED.

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.
☐ No, then you may check as many items below as you need.

Description:	**Date(s):**	**Description:**	**Date(s):**	**Description:**	**Date(s):**
☐ Dictated Reports (all)	_____	☐ Lab Reports	_____	☐ Other: _____	_____
☐ Discharge Summary	_____	☐ Pathology Reports	_____	☐ Other: _____	_____
☐ History and Physical	_____	☐ Radiology Reports	_____	☐ Other: _____	_____
☐ Consultation	_____	☐ Radiology Images	_____	☐ Other: _____	_____
☐ Operative Reports	_____	☐ Mammogram	_____		
☐ ER Reports	_____	☐ Billing Information			

I acknowledge, and hereby consent to the release of information related to diagnosis and/or treatment of the following conditions:

Alcohol or drug abuse _____ (Initial)
Genetic Information _____ (Initial)
Psychiatric Treatment or Diagnoses _____ (Initial)
HIV/AIDS testing or results _____ (Initial)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that fees in accordance with WV Law may be charged for requested copies.
6. I am entitled to a copy of this form if requested after I complete it.

Signature of Patient/Patient's Representative: _____ Date: _____

Print Name of Patient's Representative: _____ Relationship to Patient: _____

RELEASE OF INFORMATION FORM
SMMC: 16-1
Rvsd: 11/12; 3/13;8/14
Added title: 8/26/14

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2900 First Ave – Huntington, WV – 25702
Office Hours: Monday – Friday, 9:30a.m. – 4:00p.m.
Closed Daily from Noon – 1:00p.m. and Closed Holidays
www.st-marys.org