ST. Mary's Medical Center &
ST. Mary's Medical Management
2900 First Avenue
Huntington, WV 25702
304.526.1205
304.526.1174 FAX

2828 First Avenue Suite 400
Huntington, WV 25702
304.525.6905 ext. 6
304.525.1465 FAX

3075 US Route 60
Huntington, WV 25705
304.528.4600 ext. 4540
304.528.4652 FAX

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

Please select the facility from which you are requesting records: (May only select one facility per authorization form)

SMMC _____ Scott Orthopedic_____ HIMG_____ SMMM (specify office)_____
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.

Unless otherwise revoked, this authorization will expire on the following date, event or condition. If I fail to specify a date, event or condition, this authorization will expire in 90 days.
Date: Event: Condition:

Purpose of disclosure:

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED
***Please specify date of anything requested prior to 2006 ***

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization.

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 understand that my medical record may include information concerning alcohol, substance abuse, STD's, HIV/AIDS, genetic information, psychiatric treatment and or diagnoses. Signature _____

I understand that:
1. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization
2. 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
3. Information used or disclosed pursuant may be disclosed by the recipient and may no longer be protected under the rule
4. I understand that fees in accordance with WV Law may be charged for requested copies

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

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

AL16-1

«LastName» , «FirstName»
«PatientNumber» / «AdmitDate»
«Gender» / «BirthDate»
«PatientAddress1» / «AttendingDoctorName»
«Room» / «MedicalRecordNumber»