



AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health care provider; the released information may no longer be protected by federal privacy regulation.

*Social Security Number: _____

* Patient's Name: _____

*Date of Birth: _____

Patient ID by: Driver License: Other (please specify) _____

Telephone No: _____

Send Information To: (please be specific) Call to pick up.

Name/Organization _____

Purpose of Use/Disclosure: Further medical Treatment Personal Use
 Other (specify) _____

Type of Treatment You Received: _____ Date(s) of Service _____

- Inpatient _____
- Emergency Room _____
- Outpatient Surgery _____
- Other (Please specify) _____
- Permanent Transfer Mammogram Films _____

SPECIFIC INFORMATION TO BE USED/DISCLOSED:

- Entire Record Discharge Summary History & Physical Consultation
- Operative/Pathology Report X-ray Lab Other (specify) _____

The patient or patient's representative must read and initial the following statement:

1. I understand that this authorization will expire 90 days from the date signed. * Initials _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation. *Initials _____
3. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the rule. *Initials _____
4. I request that SMMC fax my information to the following number: _____ * Initials _____
5. I authorize the release of any drug/alcohol information: _____ * Initials _____

* _____

Signature of patient or patient's representative
(Form must be completed before signing)

* _____
Date

* YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*

St. Mary's Medical Center Correspondence/Release of Information (304) 526-1205/Fax (304) 526-1348

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Office Hours: Monday – Friday, 9:30a.m. – 4:00p.m.
Closed Daily from Noon – 1:00p.m. and Closed Holidays
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