



2900 First Avenue
 St. Mary's Medical Management
 2830 3rd 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



5170 US RT 60 East
 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): <input type="checkbox"/> Paper Copy <input type="checkbox"/> Electronic Media (CD/DVD) <input type="checkbox"/> 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? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization.			
Description: <input type="checkbox"/> Dictated Reports (all) <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History and Physical <input type="checkbox"/> Consultation <input type="checkbox"/> Operative Reports <input type="checkbox"/> ER Reports	Date(s): _____ _____ _____ _____ _____	Description: <input type="checkbox"/> Lab Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Radiology Images <input type="checkbox"/> Mammogram <input type="checkbox"/> Billing Information	Date(s): _____ _____ _____ _____ _____
Description: <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____			Date(s): _____ _____ _____ _____
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: _____

Authorization for Release of Information

SMMC: 16-1
 Adopted Date:
 Revised Date: 11/12, 3/13, 8/14, 4/22, 5/22
 Reviewed Date

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