Charleston Area Medical Center, Inc.

Place
Patient Identification Label
Here

AUTHORIZATION OF USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name __________________________ Date of Birth: ______________ Last 4 Digits of SSN: _____________________

FIN Number____________________________ ___________ Medical Record Number: __________________________________

FORMAT REQUESTED: ☐ **Paper** ☐ **CD** ☐ **Email** *(Also complete form number 17-7947)*

1. The following organization is authorized to disclose the above named individual's health information as described below:

   CHARLESTON AREA MEDICAL CENTER, INC ("CAMC")

2. The following person or organization is authorized to receive and/or use the information:

   ____

   ____

3. The description and amount of information to be disclosed is as follows: (include dates where appropriate)

   ____

   ____

4. The information may be used or disclosed for the following purposes: **(not required if requested by patient)**

   ____

   ____

5. Please check if permitted to disclose records pertaining to:

   ☐ Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV)
   ☐ Behavioral or mental health services
   ☐ Treatment for alcohol and drug abuse.

6 This authorization expires in thirty (30) days unless other specified: __________________________(***Expiration date***)

7. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

8. I understand that I may inspect and receive a copy of this authorization.

9. I understand that CAMC will not refuse to treat me simply because I do not sign this authorization, unless I have agreed to receive the treatment as part of a research project or in order to provide my information to a third party. Under those circumstances, I understand that my refusal to sign the authorization may result in CAMC's refusal to provide treatment.

10. I understand that I may revoke this authorization at any time in writing, except where action has already been taken in reliance upon this authorization or as stated in CAMC's Notice of Privacy Practices. The written revocation may be sent to:

    Privacy Office, 130-138 57th Street, Building 3, Unit 2, Charleston, WV 25304

______________________________________ ______________________________
Signature of Patient or Representative Date

______________________________________ ______________________________
Name of Personal Representative (if applicable) Relationship to Patient

OVER , PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

Charleston Area Medical Center

Building 3, Unit 2
130-138 57th St.
Charleston, WV
25304 (304) 388-1308

PROCESSING INFORMATION REQUIRED FOR RELEASE OF MEDICAL INFORMATION

There is a cost per page for paper medical records and tax will be applied. Records mailed directly to a physician will not be subject to a charge. A third party vendor has been contracted to provide this service and will invoice you directly.

PLEASE NOTE: There is also a charge for record copies produced in electronic format.

Requestor's Initials:__________

PATIENT INFORMATION:

(Patient Name)	(Birth Date)
(Address)	(Last 4 Digits of SSN)
(City, State, Zip)	(Home Telephone)
(Medical Record Number)	(Work Telephone)

RELEASE TO:

(Name)	(Telephone)
(Address)	(Fax Number - Physicians Only)
(City, State, Zip)	