



Charleston Area Medical Center, Inc.

Place Patient Identification Label Here

Scan To: **RELEASE of INFORMATION**

**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



**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)