



AUTHORIZATION OF USE AND DISCLOSURE OF HEALTH INFORMATION

PLACE
PATIENT IDENTIFICATION LABEL
HERE

PN Number _____

Patient Name _____ Medical Record Number _____

Date of Birth _____ Social Security Number _____

- The following organization is authorized to disclose the above named individual's health information as described below:
CHARLESTON AREA MEDICAL CENTER, INC ("CAMC")
- The following person or organization is authorized to receive and/or use the information:

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

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

- 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.
- This authorization expires in thirty (30) days unless otherwise specified: _____ (expiration date)
- 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.
- I understand that I may inspect and receive a copy of this authorization.
- 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.
- 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, 1418-C MacCorkle Ave. SW, South Charleston, WV 25303

Signature of Patient or Representative

Date

Name of Personal Representative (if applicable)

Relationship to Patient



**Charleston Area
Medical Center**

1418C MacCorkle Ave. SW
So. Charleston, WV 25303
(304) 388-1308

PROCESSING INFORMATION REQUIRED FOR RELEASE OF MEDICAL INFORMATION

There will be a \$10 retrieval fee plus .40 cents per page charge for medical records. Records mailed directly to a physician may not be subject to a charge. SMART CORPORATION has been contracted to provide this service and will invoice you directly.

Requestor's Initials: _____

PATIENT INFORMATION:

(Patient Name)

(Birth Date)

(Address)

(Social Security Number)

(City, State, Zip)

(Home Telephone)

(Medical Record Number)

(Work Telephone)

RELEASE TO:

(Location)

(Telephone)

(Address)

(Fax Number - Physicians Only)

(City, State, Zip)