Charleston Area Medical Center, Inc.

* R O 8 4 4 5 *

Scan To: **RELEASE of INFORMATION**

# AUTHORIZATION AND REQUEST FOR USE AND DISCLOSURE OF HEALTH INFORMATION FROM OTHER FACILITY

PLACE PATIENT IDENTIFICATION LABEL HERE

Patient Name _____ Date of Birth _____ Last 4 Digits of SSN: _____

FIN Number _____ Medical Record Number _____

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

   _____

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

   CHARLESTON AREA MEDICAL CENTER, INC ("CAMC")

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 otherwise 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 / Time

_____ _____

Name of Personal Representative (if applicable) | Relationship to Patient