POCAHONTAS MEMORIAL HOSPITAL

HEALTH INFORMATION SERVICES
150 Duncan Road, Buckeye, WV 24924
Phone 304-799-7400 Ext 1308 Fax 304-799-2276

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
(Patient's full name or Legal Guardian) Birthdate (Mo/Day/Year)

_____ _____
(Street address) Phone (Home or Cell)

_____ _____
(City, state, zip code) Phone (Work)

Fees are waived when copies are requested by other health care provider's agencies/facilities for continuing care. All other requestors are charged as state and federal laws allow. **Photo ID is required**.

I _____, hereby authorize Pocahontas Memorial Hospital **OR** entity listed below to
(Patient/Legal Guardian)
release copies of my medical records: _____
(Name of entity)

FORMAT REQUESTED • Paper • Electronic (email, USB, CD, Portal, other) Please specify:_____

This authorization is limited to PHI created during the time period of:
From: _____ To: _____

- **PERTINENT ELEMENTS ONLY** (***MOST RECENT DISCHARGE SUMMARY AND HISTORY AND PHYSICAL)***
- **EMERGENCY ROOM RECORD**
- **RHC OFFICE VISIT NOTES**
- **ELECTROCARDIOGRAMS**
- **LABORATORY REPORTS**
- **X-RAY AND IMAGING REPORT**
- **X-RAY/IMAGING FILM/CD**
- **Other diagnostic testing-*specify* _____**
- **OTHER, PLEASE DESCRIBE _____**
- **Snowshoe Mountain Clinic**

I understand that I am giving my permission to release information in my medical record that **may include** information relating to AIDS/HIV, sexually transmitted diseases; pregnancy information, psychiatric/behavioral, and drug/alcohol testing or treatment **unless otherwise indicated below:**

DO NOT RELEASE: (***Please initial by each that apply***) ____AIDS/HIV Results; _____ Substance abuse which includes Alcohol & Drug abuse; _____Pregnancy Test/information/Family planning; _____ Behavioral Health/Psychiatric; _____ Sexually transmitted diseases; _____ Other, please list: _____

Rev HIM 200028 Approved 02/25/2020
Rev HIM 200028 Approved 08/10/16
Replaces Rev HIM 200028 Approved 06/09/14

Purpose of Disclosure: • Personal use • Medical Care • Insurance • Attorney • Other (specify):

_____

RELEASE INFORMATION TO:

Name of person/facility	Address	Fax number
Name or person/facility	Address	Fax number
Name or person/facility	Address	Fax number

Please check below if you or someone else will be picking up your information, or should we send it to you:

• Pick up myself • I authorize pick up by _____
(Name of person)/relationship- ID must be provided at time of pickup
• 1st Class US Mail • Fax number _____ □ Email address _____

- **I hereby authorize disclosure of my protected health information to the above person/facility. This authorization is valid for one (1) year from the date of signature unless otherwise specified below.**
  _____.
  (*Expiration date)*
- **I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal regulations. I understand that Pocahontas Memorial Hospital may not condition its providing of health care on whether copies to individuals or organizations are released as I request.**
- **I understand that I may inspect and receive a copy of this authorization.**

_____ _____
Signature of Patient or Legal Representative of Patient/Date Relationship

***If authorized representative other than Parent; please sign and attach copies of supporting legal documentation. <u>Please note:</u> Medical Power of Attorney only becomes effective if the patient has been declared by a medical provider as unable to make their own health care decisions.**

FOR OFFICE USE ONLY
Prior to releasing PHI, the following ID must be obtained in order for Patient or Representative to pick up records:

• Driver's license photo ID #_____ • State-issued identification ID#_____ • Passport ID #_____
• Military identification ID# _____ • comparison of signatures documented in Protected Health Information (PHI)
• Identity verified by authorized PMH Staff member: _____

Date request received: _____
Employee releasing data: _____

<u>Note:</u> Record requests will be processed as quickly as possible; however the hospital has thirty (30) days to respond to your request for information that we maintain at our facility.

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