COVID-19 TESTING AND DIAGNOSIS AUTHORIZATION TO RELEASE INFORMATION

Employee/Student Name: ___________________ **Birth Date:**___________ **LAST 4 DIGITS OF SSN#:**_________________

Employer/School: ____ **Fax Number:** _________________________________
REQUIRED

PLEASE NOTE: A **fax number is required** at time of Registration. If fax number is unknown, please contact the Medical Records Department at the phone number/extension listed below and provide a fax number. It will be your responsibility to provide a fax number. **No results will be released without a fax number**.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Pocahontas Memorial Hospital (PMH) to disclose my identifiable health information related to my Covid-19 testing and diagnosis to **My Employer** or **My School** listed above. The purpose of the disclosure is to assist **My Employer** or **My School** in accessing and evaluationg my COVID-19 results for follow-up purposes, including quarantine, exposure evaluation, and contact tracing purposes. *In the event I am unable to obtain/submit this authorization form myself, I give my verbal authorization for PMH to release my COVID-19 test results to **My Employer** or **My School** listed above as witnessed by a Hospital Staff member whose signature appears below.* **Please note: Your COVID test result may not be faxed until the next businesss day following receipt by Medical Records personnel. The Medical Records Department hours of operation is 7:30 am to 4:00 pm M-F, excluding Holidays.**

This authorization to Release Information will be valid for one (1) year from the date of my signature. I also understand that once PMH releases my identifiable health information, federal and state privacy laws may not protect the information, and the entity receiving my information may re-disclose it.

If I change my mind and no longer wish for my identifiable health information related to my Covid-19 testing and diagnosis to be shared with **My Employer** or **My School**, I must let PMH know in writing by contacting the PMH Medical Records Department (contact information set forth below).

Note: If obtaining verbal authorization from patient, a witness must sign and date below

____ ________________________________
Patient or Patient's Legal Representative Signature Witness Date

Date: ____________________________________

Pocahontas Memorial Hospital
Medical Records Department
150 Duncan Road
Buckeye, WV 24924
(Located in same building as Pocahontas Pharmacy)
Fax: 304-799-2276
Phone: 304-799-7400 extension 1308

Results faxed by:______________________
Date