

\*\* Incomplete forms will be returned to requester\*\*

Day Phone \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ LAST 4 SSN: \_\_\_\_\_

PATIENT ADDRESS: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date (s) of Service Requested: \_\_\_\_\_ OTHER NAMES: \_\_\_\_\_

Who do you authorize to disclose your information:

- Options: Davis Medical Center, Broaddus Hospital, Other

What to release:

- Options: Office Visit Notes, ED Record, Laboratory Results, DC Summary, Pathology Reports, Immunization Records, Oncology Records, Cardiology Records, Radiology, Operative, Consult Reports, HP, Radiology Image, Billing Records, Entire Record, Other

Who do you want us to send the information to: (must be specific): \_\_\_\_\_

How do you want it sent (Choose one):

- Options: Mailed to, Fax, Delivered to patient email address, Review the chart in person, I will pick this up in person

Why/Purpose of Disclosure:

- Options: To the patient, Disability Determination, Personal, Worker's Compensation, Continuity of Care, Insurance, Litigation, Other

Authorization to Release Information:

1. I understand that, by signing this Authorization to Disclose Health Information, I am giving my permission to Davis Health System, and/or its subsidiaries ("DHS"), to disclose all the records I have specified for release to the designated recipient.

\*\*Check below any such categories of records that you are NOT authorizing DHS to release:

- Options: Behavioral/ Mental Health, Sexually Transmitted Infections, HIV, Alcohol/Drug Abuse, AIDS

NOTE: \*\* Psychotherapy Notes\*\* A separate authorization is required, although DHS is not legally obligated to provide a patient with access to Psychotherapy Notes.

Other Special Instructions, if any: \_\_\_\_\_

- 2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment, payment, enrollment in a health plan, or eligibility for benefits 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.
3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation at the address listed on page two.
4. I understand that I will be given a copy of this authorization form upon request. Furthermore, I understand that charges for record production, regardless of media used, will be applied according to State/Federal Law, and prepayment may be required.

Signature of Patient or Legal Representative \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is 12 - 17 years old, you must attest to specific exceptions on the following page BEFORE this request will be processed.





**Attestation Needed Prior to Releasing Records for Patients 12 - 17 Years Old**

I **attest** that **none** of the following apply to the child for which I am requesting records:

- (1) The minor child has graduated high school or equivalent;
- (2) The minor child is emancipated; or
- (3) The minor child is married.

**Relationship to the patient:**

- Parent
- Foster Parent
- Legal Guardian
- Kinship Placement

Documentation of relationship to patient may be required to support this request.

**Requestor's Signature:** \_\_\_\_\_

**Date / Time:** \_\_\_\_\_

**Our contact information:**

<i>Davis Medical Center</i>	<b>Phone:</b> 304-637-3381	<b>Fax:</b> 304-637-3482
Attn: Health Information		
P.O. Box 1484 Elkins WV 26241		

<i>Broaddus Hospital</i>	<b>Phone:</b> 304-457-8520	<b>Fax:</b> 304-457-2809
Attn: Health Information		
1 Healthcare Drive, Philippi WV 26416		

<i>Webster Memorial Hospital</i>	<b>Phone:</b> 304-847-5682	<b>Fax:</b> 681-691-0068
Attn: Health Information		
125 Diana Drive Webster Springs, WV 28188		



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