Charleston Area Medical Center

PLACE
PATIENT IDENTIFICATION LABEL
HERE

MRO/CAMC Release of Information
130-138 57th Street, SE
Charleston, WV 25304
Phone: (304) 388-1308
Fax: (304) 388-1195

Scan to: Release of Information

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

**PATIENT NAME:** _____ **DATE OF BIRTH**: _____
[Please print full name]

**LAST 4 SSN:** _____ **DAY PHONE**: _____ **OTHER NAMES USED:** _____

**PATIENT ADDRESS:** Street:_____City: _____ State: _____ Zip: _____

**Date (s) of Service Requested:** _____

- ☐ Office Visit Notes
- ☐ X-rays or Imaging Report(s)
- ☐ Laboratory Results
- Cath Imaging
- ☐ Pathology Reports
- ☐ Immunization Records
- Oncology Records
- Cardiology Records
- c ED Report
- Operative / Cath Report
- Consult Reports
- HP
- ED Record
- Billing Records
- Entire Record
- c DC Summary
- ☐ **Other**(be specific) : _____

**Method of Release: **Complete mailing address REQUIRED** Incomplete forms will be returned to requester.**

**Person/Facility to Receive Information (must be specific):** _____

Check the method of preferred delivery:

**Mailed to:** ***STREET:*** _____ ***CITY:*** _____ ***STATE:*** ____ ***ZIP:*** _____

☐ **Fax Number:** _____(CD will be used if over 40 pages) **Phone Number:** _____

☐ **Delivered to patient email address:** _____

**Charleston Area Medical Center (CAMC) will transfer information to the email address of your choosing. However, CAMC is not responsible for any potential risks and/or consequences if you choose to use an unsecure email address.

**Purpose of Disclosure: (If records are being delivered to patient directly this section can be blank)**

- ☐ Continuity of Care
- ☐ Disability Determination
- ☐ Insurance
- ☐ Personal
- ☐ Litigation
- ☐ Other (Please specify): _____
- ☐ Worker's Compensation

**Authorization to Release Information:**

1. I understand that, by signing this Authorization to Disclose Health Information, I am giving my permission for CAMC to disclose all of the records I have specified for release to the designated recipient. Unless indicated below , I specifically authorize the release to include such confidential health care information as may be contained in the records I have designated for release and which may relate to behavioral or mental health services, treatment for alcohol and drug abuse , sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) .

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

- ☐ Behavioral/Mental Health
- ☐ Alcohol/Drug Abuse
- ☐ Sexually Transmitted Diseases
- ☐ AIDS
- ☐ HIV

**NOTE: ** Psychotherapy Notes** A separate authorization is required, although CAMC 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. Under those circumstances, I understand that my refusal to sign may result in CAMC's refusal to treat. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM Department at 304-388-1308.

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 to Privacy Officer at the address listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 180 days from the date of signature. If applicable, insert another date or event of expiration: _____

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 pre-payment may be required. Records mailed directly to a provider will not be subject to a charge. A third party vendor has been contracted to provide this service and will invoice you directly.

**All requests are processed within 30 DAYS of receipt as permitted by State/Federal Law**.

**Signature of Patient or Legal Representative**_____
DATE

If signed by legal representative, relationship to patient: _____