Dear Charleston Area Medical Center Customer,

Thank you for trusting /KI·ꟷfŜăű2y !ꟷŜI· aŜŘꟷǑI·f /ŜyűŜꟷ (CAMC) I·yŘ ꟷűă I·ꟷꟷfꟷI·űŜă with your healthcare needs. Since technology has changed so quickly over the last few years, our medical record systems have changed and may look different.

Some of the items listed below may affect the records you receive:

- Some records from recently acquired facilities may not be owned by CAMC and will require further processing outside CAMC.
- If you were seen at any of our hospitals, physician practices, urgent care, outpatient centers, etc., over the last few years, the records will look different as they are in different medical record systems and may not be in chronological order.
- The size of scanned papers may cause a blank page to appear between pages.
- The discharge instructions received at the end of visit in our current medical record system can change if you have received new medications or got updated instructions from your physician since you were seen last.
- If you requested a copy of your bill in the past, it may look different. We are on a different billing system and the format of the bills has changed.
- Copies of photos in your chart may be in black and white.
- You may receive parts of your requested records, such as records from your physician's office, hospital, radiology or bills, at different times. If you haven't received everything you requested within three weeks of your initial request, please contact the Customer Care Center listed below.

FOR ASSISTANCE

Customer Care Center for requests sento the CAMC / Teays Valley Document Center, Greenbrier Valley, Plateau Medical Center:
For assistance or questions about your records, please reach out to our Customer Care Center at **(610)-994-7500**, Monday to Friday, from 8 a.m. to 4:30 p.m.

Our mailing addresses:

Å **CAMC/Teays Valley Document Center** Attn: MRO 130-138 57th Street, SE Charleston, WV 25304 **Fax:** 304-388-1195

Å **CAMC Greenbrier Valley Medical Center** Attn: MRO 1320 Maplewood Ave, Ronceverte WV 24970 **Fax:** 304-647-6059

Å **CAMC Plateau Medical Center** Attn: MRO 1430 Main St. , Oak Hill WV 25901 **Fax:** 304-929-2467

☐ **CAMC Cancer Center Beckley** 275 Dry Hill Road, Beckley, WV 25801 **Phone**: 304-253-6060 **Fax:** 304-253-6086

☐ **CAMC Orthopedics** 100 Tracy Way; Charleston, WV 25311 **Phone:** 304-343-4583 **Fax:** 304-343-9207

☐ **CAMC Neurosurgery** 415 Morris St., Suite 400 Charleston, West Virginia 25301 **Phone:** 304-344-3551 **Fax:** 304-342-6927

p **CAMC GVMC MSOB** 1322 Maplewood Avenue, Ronceverte, WV 24970 **Phone:** 304-647-5114 **Fax:** 304-647-3006

Informational Only - This Page Does Not Get Scanned

Charleston Area Medical Center

Scan to: Release of Information

** Incomplete forms will be returned to requester**

PLACE PATIENT IDENTIFICATION LABEL HERE

AUTHORIZATION of USE AND DISCLOSURE of HEALTH INFORMATION

DAY PHONE: _____ Please allow 7-10 days for processing your request.

PATIENT NAME: _____ **DATE OF BIRTH**: _____ **LAST 4 SSN:** _____
[Please print full name]

PATIENT ADDRESS: Street:_____ City: _____ State: _____ Zip: _____

Date (s) of Service Requested: _____ **OTHER NAMES USED:** _____

Who do you authorize to disclose your information:

o Charleston Area Medical Center, Inc (**CAMC / Teays Valley**)

p CAMC **Orthopedics and / or Neurosurgery**

☐ CAMC **Greenbrier Valley Med Center,** Inc ☐ CAMC **Plateau Medical Center,** Inc

☐ **Other:** _____

☐ CAMC **GVMC MSOB** (*formerly: Greenbrier Physicians Inc.*)

p CAMC **Cancer Center Beckley**

What to release:

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

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

How do you want it sent (Choose one):

1. ☐ **Mailed to:** ***STREET:*** _____ ***CITY:*** _____ ***STATE:*** ____ ***ZIP:*** _____
2. ☐ **Fax (Number REQUIRED):** _____(CD will be used if over 40 pages)
   Phone Number (REQUIRED) : _____
   Note: Due to file size and format, we are unable to email radiology images
3. ☐ **Delivered to patient email address:** _____
   **Charleston Area Medical Center, Inc will transfer information to the email address of your choosing. However, CAMC is not responsible for any potential risks and/or risks and/or consequences if you choose to use an unsecure email address.
4. ☐ Review the chart in person without getting a copy
5. ☐ ***I will pick this up in person***

Why/Purpose of Disclosure:

☐ To the patient - therefore, this is N/A ☐ Continuity of Care ☐ Insurance ☐ Litigation
☐ Disability Determination ☐ Personal ☐ Worker's Compensation ☐ Other (Please specify): _____

Authorization to Release Information:

1. I understand that, by signing this Authorization to Disclose Health Information, I am giving my permission for Charleston Area Medical Center, Inc., and/or its subsidiaries("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 infection, 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 Infection
☐ 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 the facility.

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 if 12 years old or older: _____ **Date:** _____

****Please note if signed by minor for release to someone besides patient, minor must sign in presence of Release of Information employee or this must be notarized by a notary ****

For those patients under 12 years old:

Signature by legal representative: _____ **Date**: _____ **Relationship:** _____

Charleston Area Medical Center

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AUTHORIZATION of USE AND DISCLOSURE of HEALTH INFORMATION

Only needs notarized by the minor if:

1. If the minor is releasing to someone besides self AND
2. The minor did not sign in the presence of Release of Information employee

Signature of Notary:

I,_____, a Notary Public in and for the County and State aforesaid, do hereby certify that _____, whose name is signed to the writing hereto annexed, bearing date the _____ day of _____, 202__, has this day acknowledged the same before me in my said County.

Given under my hand this date: _____

My commission expires: _____

_____

Notary Public Signature

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