

Medical Record # or Account #	
(Internal Office Use Only)	

Mon Health Medical Center (MHMC) Release of Information 1200 J.D. Anderson Drive Morgantown, WV 26505 Phone 304-598-1375 Fax 304-598-1399

## **Authorization for Release of Protected Health Information**

City, State, ZIP	Patient Name	— Date of Birth		
HEREBY AUTHORIZE MON HEALTH MEDICAL CENTER (MHMC) TO: RELEASE TO OR OBTAIN FROM   Address   Ad	Address	— Phone Number ———		
NameProvideriFacility	City, State, ZIP	E-mail Address ———		
Address City	I HEREBY AUTHORIZE MON HEALTH MEDICAL CENTER (M.	IMC) TO: RELEASE TO C	OR OBTAIN FROM	
Phone Number	Name/Provider/Facility			
Phone Number	Address			
RECORDS ARE REQUESTED FOR THE PURPOSE OF (Please check one)   Continuing Care/Medical Facility   Legal   Personal Use   Insurance   Other			ZIP	,
Continuing Care/Medical Facility   Legal   Personal Use   Insurance   Other	Phone Number	Fax Number		<u> </u>
Other     Other   Othe	Me (Indicated above)			
Inpatient (hospital)   Date(s)   Emergency Dept.   Date(s)   Dute(s)   Dut	RECORDS ARE REQUESTED FOR THE PURPOSE OF (Please check one)		cility Legal Personal Us	se Insurance
Outpatient Surgery Deteip Physician Office Physician/Clinic Name  PRECIFIC INFORMATION (check at that apply)  Discharge Summary  Laboratory Report(s)/Test(s) Physician Office Progress Notes  ER Dept Record Radiology Report(s)/Images - (CT, MRI, X-Ray on CD) Physician Office Progress Notes  ER Dept Record Radiology Report(s)/Images - (CT, MRI, X-Ray on CD) Physician Orders  Urgent Care Record Physician Orders  EKG Report(s) Physician Orders  Urgent Care Record Outpatient Rehabilitation Records (PT-OT-ST) Pathology Report(s) Physician Orders  Urgent Care Record Outpatient Rehabilitation Records (PT-OT-ST) Pathology Report(s) Physician Orders  Urgent Care Record Outpatient Rehabilitation Records (PT-OT-ST) Pathology Report(s) Physician Orders  Urgent Care Record Outpatient Rehabilitation Records (PT-OT-ST) Pathology Report(s) Physician Orders  Urgent Care Record Outpatient Rehabilitation Records (PT-OT-ST) Pathology Report(s) Physician Orders  Understand the released through this authorization unless otherwise indicated above unless otherwise noted below; Paper   Electronic Media/CD   Check here if you prefer to pick up the copy at: 99 J.D. Anderson Drive, Morgantown, WV 26505  **Understand the release of my records will be for the purpose stated on this form and only, those items checked off or listed will be released. This authorization automatically exp sk; (s) months from the date of the patient's or personal representative's signature.  **Understand the release of my records will be for the purpose stated on this form and only, those items checked off or listed will be released. This authorization automatically exp sk; (s) months from the date of the patient's or personal representative's signature.  **Understand the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my purposes to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim u	NFORMATION TO BE RELEASED OR OBTAINED (The next two sections many personal sections of the section of the secti	ist be completed to properly identify t	he records to be released)	
Physician Office   Physician Clinic Name	Inpatient (hospital) Date(s)	_ Emergency Dept. Date(	(s)	
Physician/Clinic Name  SPECIFIC INFORMATION (check all that apply)  Discharge Summary	Outpatient Surgery Date(s)	Outpatient Testing Date	?(s)	
Discharge Summary		. Date(s)		
Discharge Summary				
ER Depl Record	·	□Ph	vsician Office Progress Notes	
Consultation Report			,	
Operative Report   Medication Records   Outpatient Rehabilitation Records (PT-OT-ST)     Pathology Report(s)   History & Physical   Other (specify)     Hilly, Behavioral Health, and Substance Abuse information contained within the records indicated above will be released through this authorization unless otherwise indicated.   DO NOT RELEASE:   HIV   Substance Abuse/Drug & Alcohol   Behavioral Health/Psychiatric     METHOD OF DELIVERY (*Your request will be processed as soon as possible: note federal and state regulation timeframes allow thirty (30) days to process. All requests will be mailed flaxed to the address fax number indicated above unless otherwise noted below.)   Paper   Electronic Media/CD   Check here if you prefer to pick up the copy at: 99 J.D. Anderson Drive, Morgantown, WV 26505   **I understand the release of my records will be for the purpose stated on this form and only those items checked off or listed will be released. This authorization automatically expisitely (**Signature**)   **Inderstand the release of my records will not apply to my insurance company when the law provides will not apply to information that has already been released response to this authorization. I understand the revocation will not apply to information will not apply to informat				
Pathology Report(s)   History & Physical   Other (specify)			-	(PT-OT-ST)
Unless otherwise indicated. DO NOT RELEASE: HIV Substance Abuse/Drug & Alcohol Behavioral Health/Psychiatric  METHOD OF DELIVERY (Your request will be processed as soon as possible; note federal and state regulation timeframes allow thirty (30) days to process. All requests will be malled/faxed to the address/fax number indicated above unless otherwise noted below.)  Paper Electronic Media/CD Check here if you prefer to pick up the copy at: 99 J.D. Anderson Drive, Morgantown, WV 26505  • I understand the release of my records will be for the purpose stated on this form and only those items checked off or listed will be released. This authorization automatically expisic (6) months from the date of the patients or personal representative's signature.  • I understand the release of my records will be for the purpose stated on this form and only those items checked off or listed will be released. This authorization automatically expisic (6) months from the date of the patients or personal representative's signature.  • I understand the release of my records will be provided the provided the revocation will not apply to my insurance company when the law provides my insurance this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurance to this authorization. I understand the recipient may be prohibited from disclosing substance abuse information under federal substance abuse confidentially requirements.  • I understand this authorization must be signed by the patient. I understand if the patient is under eighteen (18) years of age, legally incompetent, or is unable to sign, the parent legal representative must provide authorization. I understand i may refuse to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.  • I in the case of a minor child. I certify no Court Order is currently in force that would prohibit my access to these records or prohibit my power to consent upon another person.  • I understand West Vir			•	,
**Iunderstand** the release of my records will be for the purpose stated on this form and only those items checked off or listed will be released. This authorization automatically expinsive (6) months from the date of the patient's or personal representative's signature.    **Iunderstand** I may revoke this authorization and any time, provided that I do so in writing. **Iunderstand** the revocation will not apply to information that has already been released response to this authorization. **Iunderstand** the revocation will not apply to information that has already been released response to this authorization. **Iunderstand** the revocation will not apply to information that has already been released response to this authorization. **Iunderstand** the revocation will not apply to information that has already been released responses to this authorization. **Iunderstand** the revocation will not apply to information that has already been released responses to this authorization. **Iunderstand** the revocation will not apply to information that has already been released responses to this authorization that has already been released responses to this authorization that has already been released responses to the information that has already been released responses to the information that has already been released responses to the information that has already been released responses to the information that has already been released and provided to such that have recipient and the information that has already been released as described above. In understand the information that has althorization form after my provided to the healthcare records and the information that has already been released as described above. In the case of a minor child; I certify no Court Order is currently in force that would prohibit my access to these records or prohibit my power to consent upon another person. I understand West Virginia State Laws (§16-29-2) indicates that a reasonable fee may be charged for copies of healthcare provider	unless otherwise indicated. DO NOT RELEASE: HIV Substan	ce Abuse/Drug & Alcohol	Behavioral Health/Psychiat	ric
six (6) months from the date of the patient's or personal representative's signature.  I understand I may revoke this authorization at any time, provided that I do so in writing. I understand the revocation will not apply to information that has already been released response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my p  I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal prive regulations. I understand the recipient may be prohibited from disclosing substance abuse information under federal substance abuse confidentiality requirements.  I understand this authorization must be signed by the patient. I understand if the patient is under eighteen (18) years of age, legally incompetent, or is unable to sign, the parent legal representative must provide authorization. I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.  In the case of a minor child; I certify no Court Order is currently in force that would prohibit my access to these records or prohibit my power to consent upon another person.  I understand West Virginia State Laws (\$16-29-2) indicates that a reasonable fee may be charged for copies of healthcare records and I agree to pay these fees.  I understand copies of my healthcare records that are provided for my continued care will be provided to the healthcare provider at no charge.  I certify and acknowledge that I have read this form or had it read to me. All my questions have been answered and I request that the records be released as described above.  Printed Name of Patient or Legal Representative  Minor consent under WV Law - marriage, emancipation, STD, substance/alcohol abuse, or birth control/pregnancy related care  Printed Name of Patie	Paper Electronic Media/CD Check here if you prefer to pick up	the copy at: 99 J.D. Anderson Dr	ive, Morgantown, WV 26505	
Minor consent under WV Law - marriage, emancipation, STD, substance/alcohol abuse, or birth control/pregnancy related care  Parent or Legal Guardian Power of Attorney Executor of Estate  CD CREATED BY DATE EMAILED BY DATE  Light Indentification verified by:	<ul> <li>six (6) months from the date of the patient's or personal representative's signature.</li> <li>I understand I may revoke this authorization at any time, provided that I do so in we response to this authorization. I understand the revocation will not apply to my instanding I understand that once the information is disclosed pursuant to this authorization, is regulations. I understand the recipient may be prohibited from disclosing substanding I understand this authorization must be signed by the patient. I understand if the placed representative must provide authorization. I understand I may refuse to sign payment or my eligibility for benefits.</li> <li>In the case of a minor child; I certify no Court Order is currently in force that would I understand I am entitled to a copy of this authorization form after signing.</li> <li>I understand West Virginia State Laws (§16-29-2) indicates that a reasonable fee I understand copies of my healthcare records that are provided for my continued of</li> </ul>	riting. I understand the revocation was urance company when the law provided may be re-disclosed by the recipient the abuse information under federal suration is under eighteen (18) years of this authorization and that my refusal prohibit my access to these records of may be charged for copies of healthcare will be provided to the healthcare.	rill not apply to information that has a les my insurer with the right to conte and the information may not be prostance abuse confidentiality required age, legally incompetent, or is unable to sign will not affect my ability to our prohibit my power to consent upon are records and I agree to pay these provider at no charge.	already been released in est a claim under my policeted by federal privacy ements. Die to sign, the parent or btain treatment or another person.
Minor consent under WV Law - marriage, emancipation, STD, substance/alcohol abuse, or birth control/pregnancy related care  Parent or Legal Guardian Power of Attorney Executor of Estate  CD CREATED BY DATE EMAILED BY DATE  Light Indentification verified by:	)			
Parent or Legal Guardian Power of Attorney Executor of Estate    REQUEST TAKEN BY DATE   DATE	Minor consent under WV Law - marriage, emancipation, STD, s	ubstance/alcohol		
Date/Time of Witnessed by EMAILED BY DATE		of Estate REQUEST TAKE RECORDS RELI	EN BY DA EASED BY DA	TE
Date/Time of Witnessed Witnessed by Identification verified by:				
	late/Time of Witnessed Witnessed by			rod