Authorization for Release of Protected Health Information

Patient Name: _____
Last Initial First

Date of Birth: _____

Address: _____

TO: _____

I have been a patient (or I am the patient's authorized representative). I understand that you have legally protected health information about me (or the person I represent). I understand that signing or not signing this form will not affect treatment I receive in any way.

I hereby authorize you to release to:

Weirton Medical Center / Carol Ann Slomski, MD. FACS

651 Colliers Way Ste. 307
Weirton, WV 26062
Office# 304-797-6433
Fax# 304-797-6601

The following information: **(place a check by types of records desired)**

- __ Allergy list
- __ Hospital documents (H&P, op notes, discharge summary, etc.)
- __ Lab Results
- __ Radiology Results (x-ray, CT, MRI, etc.)
- __ Medication list
- __ Problem list
- __ The above information and/or the entire Medical Record which includes HIV-Related Information.
- __ The above information and/or the entire Medical Record including mental health, drug or alcohol treatment.
- X Entire Medical Record **EXCLUDING** HIV-Related, mental health, drug, or alcohol treatment
- __ Billing or other business records **(specify)**: _____
- __ Other (specify): _____

from (date): _____ to (date): _____
(specify) **(specify)**

Reason for Request:

__ Continuing treatment __ Insurance __ Legal __ Employer __ Study/Research __ Second Opinion
__ Other _____ __ **I do not wish to disclose the reason**

This authorization will expire in six months or: _____
(specify expiration date, event or time frame for expiration)

I understand that this authorization is subject to revocation at any time, except to extent that you already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing delivered to the Privacy Officer. I understand that recipients may redisclose information which I have authorized them to receive.

X _____ X _____ _____ _____

Patient or Representative Signature Date Witness Date

(***if representative, give relationship and authority to act***) (***when required by policy or signing by mark)***