Mon Health Medical Center
Release of Information
1200 J.D. Anderson Drive
Morgantown, WV 26505

Authorization for Release of Protected Health Information

Patient Name: ______________________ **DOB:** ____________

Mailing Address: ______________________ **Phone #:** ____________

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I authorize **Mon Health Medical Center (MHMC)** to release a copy of **My Protected Health Information** to:

☐ Me (indicated above) ☐ Other Name: ______________________

Address: ______________________ Fax: ____________

______________________ Phone: ____________

For the **Date(s) of Service** from: ____________ to: ____________. (Records provided for one year if left blank)

For the purpose of: ____

For this Request, **My Protected Health Information** means (check one or more):

☐ Abstract (discharge summary, operative notes, diagnostic testing results)
☐ Discharge Summary
☐ Operative Report
☐ Diagnostic Testing Results (Lab, X-Rays, and other test results)
☐ Emergency Room Record
☐ History and Physical
☐ Pathology Report
☐ Radiology Images (on CD)
☐ Outpatient Record
☐ Other (please specify): ______________________

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<u>HIV, Behavioral Health, and Substance Abuse information contained within the records indicated above will be released through this authorization unless otherwise indicated below.</u>

DO NOT RELEASE: ☐ HIV ☐ Substance Abuse ☐ Behavioral Health/Psychiatric ☐ Other: ____________

I request that the copy be provided:

☐ Electronically on CD ☐ Electronically via E-mail to: ______________________ ☐ On Paper

I want the email: ☐ Encrypted ☐ Unencrypted

CDs and Paper copies will be mailed by default, ☐ Check Here if you prefer to Pick Up the copy at: 99 JD Anderson Drive Morgantown, WV 26505

Important: Unencrypted e-mail is not a secure method of delivery – that means it can be intercepted and seen by others. I understand that there are other risks with unencrypted e-mail including misaddressed/misdirected messages, e-mail accounts that are shared, messages forwarded to others, and messages stored on portable devices having no security. I acknowledge and accept these risks.

I understand that: My Health Record(s) will not be released by MHMC unless permission is granted by my signature on this authorization form. Only the records checked above for the dates specified will be released. It is possible that my PHI may be re-disclosed by the facility receiving my records and therefore MHMC has no responsibility or liability as a result of the re-disclosure. This authorization is valid for one year from the date of signature. I have a right to revoke this authorization at any time by sending a written request to Mon Health Medical Center, 1200 J.D. Anderson Drive, Morgantown, WV 26505 ATTN: Release of Information. My decision to revoke the authorization does not apply to any release of PHI that may have taken place prior to the date of revocation. State laws indicate that a reasonable fee may be charged for copies of healthcare records. I agree to pay this fee. Copies of records that are provided for my continued care will be mailed to the healthcare provider at no charge.

Patient Signature: ______________________ Date: ____________

OR

Legal Representative: ______________________ Date: ____________

(print name) ______________________ Relationship To Patient: ____________

Legal Representative must attach proof of authority to act on behalf of the patient (other than parent of minor)

Place Patient Label Here
(Internal Staff Only)