Mon Health
Preston Memorial Hospital
Vandalia Health

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

Preston Memorial Hospital (PMH)
Release of Information
150 Memorial Drive
Kingwood, WV 26357
Phone 304-329-3220
Fax 304-329-2822

Authorization for Release of Protected Health Information

Patient Name _____ Date of Birth _____

Address _____ Phone Number _____

City, State, ZIP _____ E-mail Address _____

I HEREBY AUTHORIZE PRESTON MEMORIAL HOSPITAL (PMH) TO: ☐ **RELEASE TO OR** ☐ **OBTAIN FROM**

☐ Name/Provider/Facility _____

Address _____

City _____ State _____ ZIP _____

Phone Number _____ Fax Number _____

☐ Me (Indicated above)

RECORDS ARE REQUESTED FOR THE PURPOSE OF *(Please check one)* ☐ Continuing Care/Medical Facility ☐ Legal ☐ Personal Use ☐ Insurance

☐ Other _____

INFORMATION TO BE RELEASED OR OBTAINED *(The next two sections must be completed to properly identify the records to be released)*

TYPES OF RECORDS *(check all that apply)*

☐ Inpatient (hospital) *Date(s)*_____ ☐ Emergency Dept. *Date(s)*_____

☐ Outpatient Surgery *Date(s)*_____ ☐ Outpatient Testing *Date(s)*_____

☐ Physician Office_____ *Date(s)*_____
Physician/Clinic Name

SPECIFIC INFORMATION *(check all that apply)*

☐ Discharge Summary
☐ ER Dept Record
☐ Consultation Report
☐ Operative Report
☐ Pathology Report(s)
☐ Laboratory Report(s)/Test(s)
☐ Radiology Report(s)/Images - (*CT, MRI, X-Ray on CD*)
☐ EKG Report(s)
☐ Medication Records
☐ History & Physical
☐ Physician Office Progress Notes
☐ Physician Orders
☐ Urgent Care Record
☐ Outpatient Rehabilitation Records *(PT-OT-ST)*
☐ Other *(specify)* _____

HIV, 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/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: **150 Memorial Drive, Kingwood, WV 26357**

- ***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 expires 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 in 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 policy.*
- ***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 privacy 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 or 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*** *I am entitled to a copy of this authorization form after signing.*
- ***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.*

/
Date/Time of Signature

Signature of Patient or Legal Representative ***(if applicable proof required)***
Minor consent under WV Law - marriage, emancipation, STD, substance/alcohol abuse, or birth control/pregnancy related care

Printed Name of Patient or Legal Representative

☐ **Parent or Legal Guardian** ☐ **Power of Attorney** ☐ **Executor of Estate**

/
Date/Time of Witnessed

Witnessed by

FOR OFFICE USE ONLY
REQUEST TAKEN BY _____ **DATE** _____
RECORDS RELEASED BY _____ **DATE** _____
CD CREATED BY _____ **DATE** _____
EMAILED BY _____ **DATE** _____
Identification verified by:
☐ **Patient Known To Staff** ☐ **Photo ID** ☐ **Signature Checked**