Mon Health
Preston Memorial Hospital

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

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

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.*
- ***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

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

_____
Printed Name of Patient or Legal Representative

/
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**