



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

Grafton City Hospital
Release of Information
1 Hospital Plaza
Grafton, WV 26354
Phone 304-265-0400
Fax 304-265-3169

Authorization for Release of Protected Health Information

Patient Name _____ Date of Birth _____
Address _____ Phone Number _____
City, State, ZIP _____ E-mail Address _____

I HEREBY AUTHORIZE GRAFTON CITY HOSPITAL 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 Laboratory Report(s)/Test(s) Physician Office Progress Notes
 ER Dept Record Radiology Report(s)/Images - (CT, MRI, X-Ray on CD) Physician Orders
 Consultation Report EKG Report(s) Urgent Care Record
 Operative Report Medication Records Outpatient Rehabilitation Records (PT-OT-ST)
 Pathology Report(s) History & Physical 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: 1 Hospital Plaza, Grafton, WV 26354

- 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
 Parent or Legal Guardian Power of Attorney Executor of Estate

Printed Name of Patient or Legal Representative _____

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

/ _____
Date/Time of Witnessed Witnessed by