Mon Health
Preston Memorial Hospital
Vandalia Health

Incomplete forms will be returned to requester

AUTHORIZATION of USE AND DISCLOSURE of HEALTH INFORMATION

Day Phone: _____ Please allow 7-10 days for processing your request.

Patient Name: _____ Date of Birth: _____ Last 4 SSN: _____

Patient Address: *Street:* _____ City: _____ State: _____ Zip: _____

Date(s) of Service Requested: _____ Other names used: _____

Who do you authorize to disclose your information:

- ☐ Preston Memorial Hospital (PMH)
- ☐ PMH Clinic (be specific): _____

What to release:

☐ Office Visit Notes	☐ Pathology Reports	☐ ED Report	☐ ED Record	☐ Billing Records
☐ Radiology images	☐ Imaging Report	☐ Immunization Records	☐ Operative /Cath Report	☐ Entire Record
☐ Laboratory Results	☐ Oncology Records	☐ Consult Reports	☐ DC Summary	☐ Cath Imaging
☐ Cardiology Records	☐ History & Physical	☐ Other (be specific): _____		

Who do you want us to send the information to: (must be specific): _____

How do you want it sent (Choose one):

1. ☐ Mailed to: Street: _____ City: _____ State: _____ Zip: _____
2. ☐ Fax (Number REQUIRED): _____ (CD will be used if over 40 pages)
3. ☐ Delivered to patient email address: _____
   ** Preston Memorial Hospital will transfer information to the email address of your choosing. However, PMH is not responsible for any potential risks and/or risks and/or consequences if you choose to use an unsecure email address.
4. ☐ Review the chart in person without getting a copy
5. ☐ ***I will pick this up in person***

Why/Purpose of Disclosure:

☐ To the patient – therefore, this is N/A	☐ Continuity of Care	☐ Insurance	☐ Litigation
☐ Disability Determination	☐ Personal	☐ Worker's Comp	☐ Other (Please specify): _____

Authorization to Release Information:

1. I understand that, by signing this Authorization to Disclose Health Information, I am giving my permission for Preston Memorial Hospital and/or its subsidiaries ("PMH"), to disclose all of the records I have specified for release to the designated recipient. Unless indicated below, I specifically authorize the release to include such confidential health care information as may be contained in the records I have designated for release and which may relate to behavioral or mental health services, treatment for alcohol and drug abuse, sexually transmitted infection, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV).

** Check below any such categories of records that you are NOT authorizing PMH to release:

☐ Behavioral/Mental Health	☐ Sexually Transmitted Infection	☐ HIV
☐ Alcohol/Drug Abuse	☐ AIDS	

NOTE: ** Psychotherapy Notes** A separate authorization is required, although MHMC is not legally obligated to provide a patient with access to Psychotherapy Notes.

Other Special Instructions, If any: _____

2. I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign this authorization. I need not sign this form to ensure treatment, payment, enrollment in a health plan, or eligibility for benefits unless I have agreed to receive the treatment as part of a research project or to provide my information to a third party. Under those circumstances, I understand that my refusal to sign may result in PMH's refusal to treat. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM Department at the facility.

3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer at 1200 J D Anderson Drive, Morgantown, WV 26505. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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. Unless otherwise revoked, this authorization will expire 180 days from the date of signature. If applicable, insert another date or event of expiration: _____

4. I understand that I will be given a copy of this authorization form upon request, Furthermore, I understand that charges for record production, regardless of media used, will be applied according to State/Federal Law, and pre-payment may be required. Records mailed directly to a provider will not be subject to a charge.
   All requests are processed within 30 DAYS of receipt as permitted by State/Federal Law.

Signature of Patient or Legal Representative _____ Date: _____

If a patient is 12-17 years old, you must attest specific exceptions on the following page **BEFORE** this request will be processed.

(revised 7/03/2025)

Patient Label

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Attestation Needed Prior to Releasing Records for Patients 12-17 Years Old

I **attest** that **none** of the following apply to the child for which I am requesting records:

(1) The minor child has graduated high school or equivalent.
(2) The minor child is emancipated; or
(3) The minor child is married.

Relationship with the patient:

☐ Parent

☐ Foster Parent

☐ Legal Guardian

☐ Kinship Placement

Documentation of relationship to patient may be required to support this request.

Requestor's Signature: _____

Date / Time: _____

Our mailing address for the following facilities:

Preston Memorial Hospital

Attn: HIM 150 Memorial Drive, Kingwood, WV 26537 Phone: 304-329-3220 / Fax: 304-329-2822

(revised 7/03/2025)

Patient Label