



Dear Requestor:

In order for us to provide you with the best service possible, please take a few moments to read the following information before completing the attached authorization for copies of medical records

Please provide us with all requested information; leave no lines blank and initial where indicated. If you are requesting the records of a deceased individual, documentation that you are the administrator/executor of his or her estate is mandatory.

If you are a patient's representative, you must provide us with Surrogate or Power of Attorney papers. This information is necessary to ensure that St. Mary's Medical Center is in full compliance with federal patient privacy laws.

While every request is important to us, priority must be given to record requests necessary for continuation of care. For other requests, federal law allows up to 30 days for completion.

Continuation of care requests for other healthcare providers will be mailed to the provider at no charge to you. **However, in the State of West Virginia, there is a \$10.00 retrieval fee and \$.40 per page copy fee for all other requests.**

Please do not hesitate to ask any staff member of Hospital Information Management for clarification of any information contained in this letter.

Sincerely,

Health Information Management Department  
(304) 526-1205  
(304)526-1348 (fax)

**\*PLEASE RETURN ALL ENCLOSED PAGES**



# ST. MARY'S MEDICAL CENTER

## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health care provider; the released information may no longer be protected by federal privacy regulation.

**Patient's Name:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_  
**Patient ID by :** \_\_\_\_\_ Driver License; **Other** (please specify) \_\_\_\_\_  
**Telephone No:** \_\_\_\_\_

**Send Information To:** (please be specific) \_\_\_\_\_ Call to pick up  
Name/Organization \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Purpose of Use/Disclosure:**  Further medical treatment  personal use  
 Other (specify) \_\_\_\_\_

**Type of Treatment You Received:** (include dates if possible)  
Date(s) of Service \_\_\_\_\_  
 Inpatient \_\_\_\_\_  
 Emergency Room \_\_\_\_\_  
 Outpatient Surgery \_\_\_\_\_  
 Other(please specify) \_\_\_\_\_

### SPECIFIC INFORMATION TO BE USED/DISCLOSED:

Entire Record  Discharge Summary  History & Physical  Consultation  
 Operative/Pathology Report  X-ray  Lab  Other(specify) \_\_\_\_\_

The patient or patient's representative must read and initial the following statement:

1. I understand that this authorization will expire 90 days from the date signed. **Initials** \_\_\_\_\_
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation. **Initials** \_\_\_\_\_
3. The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the rule. **Initials** \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or patient's representative \_\_\_\_\_  
Date  
**(Form must be completed before signing)**

### \* YOU MAY REFUSE TO SIGN THIS AUTHORIZATION\*

St. Mary's Medical Center Correspondence/Release of Information (304) 526-1205/Fax (304) 526-1348  
2900 First Ave – Huntington, WV – 25702  
Office Hours: Monday – Friday, 9:30a.m. – 4:00p.m.  
Closed Daily from Noon – 1:00p.m. and Closed Holidays  
[WWW.ST-MARYS.ORG](http://WWW.ST-MARYS.ORG)