St. Francis Hospital | 333 Laidley Street | Charleston, WV 25301 | Ph: 304.347.6606 | Fax: 304.347.6274
St. Francis Hospital Spine and Nerve Center | 400 Court Street, Suite 302 | Charleston, WV 25301 | Ph: 304.347.6120 | Fax: 304.347.6207
Thomas Memorial Hospital | 4605 MacCorkle Ave., SW | South Charleston, WV 25309 | Ph: 304.766-3742 | Fax: 304.766.3745 304.766.3744

Thomas Health

* C O O 1 1 0 *

PATIENT LABEL

AUTHORIZATION/CONSENT FOR THE RELEASE OF MEDICAL RECORDS

I hereby authorize Saint Francis Hospital, The Spine and Nerve Center, and/or Thomas Memorial Hospital to release the following information from the medical records of

Patient Name _____ **Date of Birth** _____

Street Address (City/State/Zip) _____ **Phone**_____

Email Address _____

Treatment Date(s)_____

Information to be released:

- ◯ Face Sheet
- ◯ History & Physical
- ◯ Operative Report
- ◯ Discharge Summary
- ◯ Consultation
- ◯ Progress Notes
- ◯ Emergency Room Record
- ◯ Test Results
- ◯ Films on CD
- ◯ Billing
- ◯ Psychiatric Records — Initial
- ◯ Alcohol and/or Drug Abuse Records — Initial
- ◯ HIV Information — Initial

Other _____

Information is to be released to: _____

Purpose of release/disclosure: _____

Format Requested: ◯ Paper ◯ Email ◯ CD ◯ Fax *(only applies to other Medical Facilities)*

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

Specification of the date, event, or condition upon which this consent expires **(not to exceed six months from the date of signature/execution of consent)**: _____

Thomas Health, its employees/agents/officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Treatment, payment or other benefits may not be conditional upon execution of this authorization. Any protected health information disclosed per this authorization may be re-disclosed by the recipient.

_____ _____
Patient or Representative Signature **Date**

_____ _____ _____
Relationship to Patient **Identity Verification** **Verified by (Name)**

_____ _____
Witness **Date**

****There is a fee charged for the retrieval and the copying/reproduction of all records.**