

**AUTHORIZATION/CONSENT FOR THE RELEASE OF MEDICAL RECORDS**

I hereby authorize Thomas Health (Saint Francis Hospital, Thomas Memorial Hospital, and/or Thomas Health Physician Partners) and/or \_\_\_\_\_ 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
- Alcohol and/or Drug Abuse Records
- HIV Information
- Psychiatric Records
- Films on CD
- Billing
- Other \_\_\_\_\_

Initial \_\_\_\_\_  
Initial \_\_\_\_\_  
Initial \_\_\_\_\_

**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 of 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** **Identify Verification** **Verified by (Name)**

\_\_\_\_\_  
**Witness** **Date**

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

**Saint Francis Hospital** | 333 Laidley Street | Charleston, WV 25301 | Ph: 304.347.6606 | Fax: 304.347.6274  
**Thomas Health Physician Partners** | 400 Division Street, Suite 2 | South Charleston, WV 25309 | Ph: 304.347.6606 | Fax: 304.766.3745  
**Thomas Memorial Hospital** | 4605 MacCorkle Ave., SW | South Charleston, WV 25309 | Ph: 304.347.6606 | Fax: 304.766.3745 or 304.766.3744

