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
- ☐ Other _____
- ☐ Consultation
- ☐ Progress Notes
- ☐ Test Results
- ☐ Emergency Room Record
- ☐ Billing
- ☐ Films on CD
- ☐ Alcohol and/or Substance Abuse Records — Initial _____
- ☐ HIV Information — Initial _____
- ☐ Psychiatric Records — 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.

Submit Form

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: 304.347.6274
Thomas Memorial Hospital | 4605 MacCorkle Ave., SW | South Charleston, WV 25309 | Ph: 304.347.6606 | Fax: 304.347.6274

USE LABEL OR PRINT PATIENT ID HERE

CO0110

ThomasHealth