St. Mary's Women & Family Care Center
143 Peyton Street
Barboursville, WV 25504

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.

Social Security Number: _____

Patient's Name: _____ Date of Birth: _____

Persons/organization providing the information: _____

_____

Persons/organization receiving the information: _____

_____

Specific description of information (including date[s])_____

_____

Reason for release: _____

_____

CHECK ONE

☐ Copy of medical records of St. Mary's _____
☐ Copy of medical records prior to St. Mary's _____ (specify dates above).
☐ Other(please describe) _____

_____
Physician's Name

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 actions they took before they received the revocation.
   Initials _____

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

Printed name of patient's representative: _____
Relationship to patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION