Grant Memorial Hospital
PO Box 1019
Petersburg, WV 26847
Telephone (304)-257-1026 Fax (304)-257-1923

Release of Information Authorization Form

_____ _____ _____ _____
Name of Patient Date of Birth SSN (last 4 digits) Patient Number

_____
Address City/State/Zip

Covering the period(s) of health care: From_____ to_____ From_____ to_____

1.Information to be disclosed by Grant Memorial Hospital:

☐ Consultation	☐ EKG,EEG	☐ Laboratory	☐ Progress Note
☐ Discharge Summary	☐ Face Sheet	☐ Operative Report	☐ X-ray
☐ ER records	☐ History and Physical	☐ Path Report	☐ Other (Specify)_____

2. **I understand and acknowledge that this will include information relating to (check if applicable):**

☐ acquired immunodeficiency syndrome (AIDS) ☐ treatment for alcohol and/or drug abuse

☐ behavioral health service/psychiatric care ☐ human immunodeficiency virus (HIV)

3. This information is to be disclosed (whether in print, electronic, or any other form) to:
_____

for the purpose(s) of _____.

4. This information can also be disclosed to the following individuals:

Name	Relationship	Identification	Verified
_____	_____	_____	_____
_____	_____	_____	_____

5. I understand this authorization may be revoked in writing at any time by providing a signed and dated revocation in writing to Grant Memorial Hospital (at the above-listed address), except to the extent that Grant Memorial Hospital has made a use or disclosure, or otherwise has taken action in reliance on this authorization. Unless otherwise revoked, this authorization will expire one (1) year from date of signing or on the following date, event, or condition: _____ _____
Initial Date

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6. I understand that treatment, payment, enrollment, and other benefits may not be conditioned upon my signing of this authorization.

7. I understand that information disclosed pursuant to this authorization may be redisclosed by the receiving entity/person without my knowledge or permission, and that such redisclosure may result in the information disclosed pursuant to this authorization becoming no longer protected by the Health Information Portability and Accountability Act of 1996, and its implementing regulations (HIPAA).

8. This authorization does not enable Grant Memorial Hospital to disclose Psychotherapy Notes include notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of the conversion during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of my medical record. Psychotherapy Notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnoses, functional status, the treatment plan, symptoms, prognosis, and progress to date.

9. I am entitled to receive a copy of this signed Authorization.

_____ _____ _____
Signature of patient/ Personal Representative (Relationship to Patient) Date/Time

_____
Second Signature (if needed)

_____
Signature of person giving out records