Patients can now complete and submit release form electronically

WVU Medicine
THOMAS HOSPITALS

Scan this QR code with the camera from your phone or tablet

Or go directly to **bit.ly/ThomasMedicalRecords**

AUTHORIZATION FOR RELEASE OF INFORMATION – BEHAVIORAL HEALTH FACILITY

I. Patient Information

Full Name of Patient: _____ Date of Birth: _____
Address: _____ Last four of SSN: _____
Phone: _____

II. Disclosure

Information to be (select one): □ sent to patient □ sent to provider □ hand carried (photo ID required)

I hereby authorize Health Information Management to disclose the following documentation (select all that apply):

☐ History and Physical	☐ Evaluation(s)	☐ Progress Note Summary
☐ Discharge Summary Plan	☐ Discharge Summary	☐ Intake Assessment
☐ Treatment Plan and Updates	☐ Abstract Summary	☐ Medication Information
☐ Lab Information	☐ Drug/Breathalyzer Screening Results	☐ Summary Letter

Other: _____

To: _____
(Name of Facility/Provider and complete mailing address and phone number)

For the purpose of: _____

For the period of time from _____ to _____

I understand that this authorization extends to all or any part of the records/information designated above, which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnosis.

I understand the nature of this Release and freely give(s) consent

Patient Signature (age 10 and up): _____ Date: _____
Parent/Guardian Signature: _____ Date: _____
Witness Signature: _____ Date: _____

REVOCATION: I have the right to stop this release of information at any time. I understand that I cannot do anything about information already disclosed under this Authorization. Revocation must be submitted in writing, signed, dated, and handed to the Release of Information Technician. My decision to revoke the authorization may result in my insurance company not being able to pay for the medical care, and I may be liable for payment of the claims. I understand that this facility cannot require me to sign this authorization in order to receive treatment.

EXPIRATION: Unless revoked earlier, this Authorization expires 90 days from the date of my signature.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from the records whose confidentiality may be protected by 42 C.F.R. Part 2. These federal regulations prohibit you from making any further disclosure without specific written consent of the person to whom these medical records pertain, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.