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**

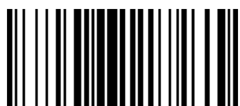
______________ ______________ ______________
Relationship to Patient **Identify Verification** **Verified by (Name)**

______________________________ ______________
Witness **Date**

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

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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WVU Medicine
THOMAS HOSPITALS