**CABELL HUNTINGTON HOSPITAL**
1340 Hal Greer Blvd.
Huntington, WV 25701

**Health Information Management**
Phone Number: 304-526-2010
Fax Number: 304-526-2012
**Radiology Film/CD**
Fax Number: 304-399-2725

## AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Patient Name _____ DOB _____ SS# _____

Address _____

_____

**SEND INFORMATION TO**: (please be specific) _____

Name/Organization _____ Daytime phone _____

Address: _____ City, State, and Zip: _____

**PURPOSE OF USE/DISCLOSURE**: ☐ Further medical treatment ☐ personal use ☐ At the request of the patient

Other: (Specify) _____

**FORMAT REQUESTED:** ☐ Paper ☐ Electronic

**SPECIFIC INFORMATION TO BE USED/DISCLOSED (INCLUDE DATES OF SERVICE IF POSSIBLE):**

☐ Entire Record ☐ Other (specify) _____

*******May require specific dates of service for records prior to 2007*******

**DISCLOSURES REQUIRING SPECIAL CONSENT**:

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

☐ HIV/AIDS Virus _____ Signature

☐ Drug, Alcohol Abuse/Treatment _____ Signature

☐ Protected Health Information on a minor _____ Signature of Minor

☐ Psychiatric/Mental Health _____ Signature

I authorize the use or disclosure of health information as specified above. I understand that authorizing the use or disclosure of this health information is voluntary and treatment, payment or other benefits may not be conditioned on the execution of this authorization. **I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy standards.** I understand that I have a right to revoke this authorization at any time, providing the information has not already been used or disclosed. I understand I must do so in writing and present it to the Health Information Management Department at Cabell Huntington Hospital.
**Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.**

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
If I fail to specify an expiration date, event or condition, this authorization will expire in 1 year.

_____ _____ _____
Signature of patient or Legal Representative Date Witness
Attach copy of legal documentation (i.e. POA, Executor)

***MRO HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY.*** **NO CHARGE APPLIES FOR RECORDS PROVIDED DIRECTLY TO A PHYSICAN. TO CHECK THE STATUS OF A REQUEST, PLEASE CONTACT MRO Requester Services at 610-994-7500 Option 1.**