Boone Memorial Hospital

Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____

Street Address or P.O. Box: _____

City, State & Zip Code: _____

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

1 I authorize the use or disclosure of the above named individual's health information, as described below.

The following individuals or organizations are authorized to make the disclosure: Boone Memorial Hospital &/or its clinics / 701 Madison Avenue / Madison, WV 25130

2 The type and amount of information to be used or disclosed is as follows (check the appropriate item(s), and include other information, where indicated):

- □ Most Recent ER record
- □ Most Recent 6 mos Diagnostics (labs/XR/EKG/etc)
- □ Laboratory Results from _____(date) to _____(date)
- □ Xray and/or imaging reports from _____(date) to _____(date)
- □ Other outpatient testing (specify with dates) _____
- □ Other (please describe) _____
- □ Complete File (all available information)

3 **I understand that the information in my health record may include information relating to any sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.**

4 This information may be disclosed to, and used by, the following individuals or organizations:
Name _____
Address _____

5 This information is being disclosed for the following purpose(s):
□ Medical □ Legal □Personal □Insurance
□ Other (specify) _____

By signing this Authorization, I am permitting the disclosure and sharing of my health and medical information for the purpose described above. I understand that this authorization is voluntary. This Authorization will expire 90 days after signature. I may revoke this Authorization, in writing, except to the extent that you have already relied upon it in making a disclosure. My written revocation will become effective when you receive it. I understand once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand WV Code 16-29-1 allows for a reasonable charge to complete this request for health information.

_____ _____ _____
Signature Date Title, if legal representative*

_____ _____
Witness Date

* If you are submitting this request on behalf of this individual as their legal representative please provide documentation indicating your designation as such.