For Office Use Only:
Verified: Yes / No
By:_____
D.Lic #: _____
SS #: _____
Signature: Yes/No

CLINCH VALLEY MEDICAL CENTER

6801 Gov. G. C. Peery Hwy, Richlands, VA 24641

AUTHORIZATION/REQUISITION (circle one)

FOR RELEASE OF INFORMATION

SECTION A: (This section to be completed by the patient)

Patient's Name: _____ Medical Record #/ID number: _____

Date of birth: _____

List the specific information that is authorized for disclosure:

Dates of Service/Encounter to be released: _____

☐ Anesthesia	☐ Consultation	☐ **Discharge Sum**	☐ EKG's	☐ Emergency	☐ Facesheet
☐ History/Phys	☐ Imaging Rpts	☐ Laboratory	☐ Medication	☐ Nursing	☐ Surgery/Proc
☐ Orders	☐ Outpatient	☐ Pathology	☐ Progress Nts	☐ Billing Rec	☐ UB04
☐ Itemized Bill	☐ Acct of Discl	☐ Entire Record	☐ Other	☐ _____	☐ _____

Name of Recipient: Enter the name/address/city/state/zip code and phone number of which the information can be released to or from: _____

_____

Describe the purpose / reason for this request:_____

SECTION B: (Patient must read and complete information in this section)

I hereby authorize *Clinch Valley Medical Center* to use/disclose my individually identifiable health information in the manner described within this authorization.

Do you want the Hospital/Clinic to release your psychotherapy notes (if any) to the person or facility you have listed above?
Circle One: Yes No _____ (initial here)

- I understand that the persons hereby authorized to use/disclose information will not condition treatment or payment on my providing this authorization or that refusal to sign this authorization will not affect my treatment.
- I understand that information used or disclosed to an entity other than a health plan or health care provider may be subject to re-disclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 CFR160 and 164.
- I understand that this authorization will expire on ____/____/____. (If no date is written, this authorization will expire one year from the date on which it is received by the hospital.)
- I understand that I may revoke this authorization at any time by notifying [enter facility/practice name] in writing, except to the extent that has already taken in reliance of the previous authorization period.
- I understand that if my records contain sensitive information that I may need to have by physician authorize the use of disclosure of it.
- I understand that I have the right to see this information described on this form if I ask to see it and I understand that I may request a copy of this form after I sign it.

_____ _____ _____

Signature of Patient or Patient's Representative **Date** **Time**

If not signed by patient, please indicate relationship: ☐ Parent or guardian of minor patient ☐ Guardian or conservator of incompetent patient ☐ Beneficiary or representative of deceased patient

Clinch Valley Medical Center

Release of Information

PHYSICIAN

ADM DOB SEX AGE fye7407