Hawse Health

(304) 897-5915
FAX (304) 897-6216
PO Box 97
Baker, WV 26801
HAWSEHEALTH.COM

AUTHORIZATION TO RELEASE OR OBTAIN CONFIDIENTIAL MEDICAL INFORMATION

_____ _____
Last Name, First Name, MI *Date of Birth*

_____ _____
Address *Last 4 numbers of SSN*

_____
Home Phone Number *Work Phone Number*

AUTHORIZATION

I HEREBY AUTHORIZE:

Name/Organization: _____

Address: _____

Phone Number: _____ Fax Number: _____

TO RELEASE MEDICAL INFORMATION TO:

Name/Organization: _____

Address: _____

Phone Number: _____ Fax Number: _____

FOR DATES OF SERVICE: _____

[ ] Medication List [ ] Last office visit note [ ] Laboratory Results [ ] Mammogram
[ ] Well Child Visit [ ] PAP Test Results [ ] GYN Records [ ] X-Ray/Imaging Results
[ ] Immunization Record [ ] Consultation Reports [ ] Full Medical Record [ ] Problem Summary List

I understand the release of the following information requires special authorization. Please initial if you wish this information to be requested or released:

_____ HIV Results or information conveying HIV results
_____ Behavioral /Mental Health/Psychotherapy notes and related medication records
_____ Records related to treatment of substance/alcohol abuse.

Purpose of request: [ ] Continued Care [ ] Legal [ ] Insurance [ ] Changing providers [ ] Other _____

Attestations:

___ I understand that this consent is voluntary and that I may revoke in writing, signed and dated for E. A. Hawse Health Center. This request will expire in 365 days from the date of signature.
___ I may refuse to sign this authorization. If I refuse, the medical records will not be accepted or released.
___ Releases or requests meet the requirements of HIPAA
___This release/request has been [ ] accepted [ ] rejected by the patient's representative of record

_____ _____ _____
Patients Signature Guardian Signature Date

Released by: _____ Date: _____

Cd6:\authorizationtoreleaserecords\blt\3.13.13

Accessible Affordable Quality Care Since 1981