HAWSE HEALTH

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: E. A. Hawse Health Center
Address: P.O. Box 97 Baker, WV 26801
Phone Number: 304-897-5915 Fax Number: 304-897-5917

Circle Provider to see: James Rising Don Harris Kelli Eglinger Lisa Basye Elizabeth Smith

DATES OF SERVICE: FROM_____ TO_____
[ ]Medication List [ ]Office Notes [ ]Laboratory Results [ ]Mammogram
[ ]Well Child Visit [ ]Pap Result [ ]X-Ray/Imaging Results [ ]Immunization Records
[ ]Full Medical Records

Purpose of Request: [ ]Continued Care [ ]Legal [ ]Insurance [ ]Changing Providers [ ]Other_____

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

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:** _____

E. A. Hawse Health Center, Inc.
PO Box 97, 17978 State Route 55, Baker, West Virginia 26801
Ph: 304-897-5915 Fax: 304-897-6216