



**HAWSE HEALTH**

**AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL MEDICAL INFORMATION**

\_\_\_\_\_  
Last Name, First Name, MI  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
Home Phone Number                      Work Phone Number

\_\_\_\_\_  
Date of Birth  
\_\_\_\_\_  
Last 4 numbers of SSN

**AUTHORIZATION**

**I HEREBY AUTHORIZE:**

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

**TO RELEASE MEDICAL INFORMATION TO:**

Name/Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Circle Provider to see:**   Mark Puffenberger      Lisa Basye      Elizabeth Smith      Elizabeth Hott      Chantel Coby

**DATES OF SERVICE:**    **FROM** \_\_\_\_\_                      **TO** \_\_\_\_\_

- Medication List       Office Notes       Laboratory Results       Pap & Pathology Record
- Well Child Visit       Mammogram       X-Ray/Imaging Results       Immunization Records
- Eye Exams       Dexa Scan       GYN Records       Colonoscopy & Pathology Record
- 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:** \_\_\_\_\_