CABIN CREEK HEALTH CENTER
Route 79, P.O. Box 70
Dawes, WV 25054
(304) 595-5006

CLENDENIN HEALTH CENTER
301 Elk River Road S.
Clendenin, WV 25045
(304) 548-7272

RIVERSIDE HEALTH CENTER
Suite 103, One Warrior Way
Belle, WV 25015
(304) 949-3591

SISSONVILLE HEALTH CENTER
7133 Sissonville Drive
Sissonville, WV 25320
(304) 984-1576

Request for Protected Health Information

Patient Name (Print full name):_____

SSN:_____ DOB:_____ Former name(s):_____

By signing this authorization form, I understand that I am giving my authorization to: _____ to disclose and release the protected health information to: Cabin Creek Health Systems, for the date(s) of service and/or for the following treatment(s): _____.

My protected health information is to be sent to: circle one

Cabin Creek Health Center	Clendenin Health Center	Sissonville Health Center	Riverside Health Center
ST RT 79 Box 70	301 Elk River Rd. S.	7133 Sissonville Dr.	#1 Warrior Way, Suite 103
Dawes, WV 25054	Clendenin, WV 25045	Sissonville, WV 25320	Belle, WV 25015
(304) 595-5006	(304) 548-7272	(304) 984-1576	(304) 949-3591

You may use or disclose the following health care information (initial all that apply):

_____ Progress Notes
_____ Lab
_____ X-Ray
_____ Cardiac
_____ Procedures
_____ Well Child Exams/Vaccinations
_____ Medication
_____ Referral
_____ Prenatal
_____ Other: (specify):_____

You may use or disclose health care information regarding testing, diagnosis, and treatment for: (initial all that apply):

_____ HIV (AIDS virus)
_____ Sexually Transmitted Diseases
_____ Psychiatric disorders/mental health (other than psychotherapy notes)
_____ Drug and/or alcohol use (further re-disclosure limited or prohibited by 42 CFR Part 2)
_____ Psychotherapy notes (if applicable, no other information can be released pursuant to this authorization).

Reasons for this authorization (check all that apply):

_____ For _____'s use for _____

_____ Other:_____

_____ Transfer of care. Please list reason why:_____

_____ Check only if it is for marketing purposes.

I authorize the release of the PHI identified above (intial):

_____ Created on or before this date of this request only.

_____ Created on or before the date of this request and created after the date of this request for health care services I receive for a period up to and including the expiration date listed below. I understand there will be an additional charge for providing future information, and I agree to reimburse Cabin Creek Health Systems for providing this information in accordance with the fee schedule for copying and mailing these records.

This authorization ends: (This document does not permit disclosure of health information for a period of more than six months after the date it is signed.):

____ _____ days from the date signed (not to exceed 180) ____ On Date:_____

____ When the following event occurs:_____

If no date or event is stated, expiration will be six months from the date signed. We cannot use or disclose the requested information after expiration of this authorization without the execution and delivery to us of a new authorization.

- I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment) and that I may refuse to sign this authorization. However I do have to sign an authorization form to take part in a research study, or to receive health care for the express purpose of creating health care information for a third party (i.e. Insurance Physical).
- I understand that this authorization may be revoked in writing and delivered to the Cabin Creek Health Systems Privacy Officer at any time, although revocation will not be effective as to the use and/or disclosure of information that has been previously authorized or where actions have been taken in reliance on an authorization I have signed.
- I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient, and if so, may not be subject to federal or state laws protecting it's confidentiality
- **I do understand that Cabin Creek Health Systems has <u>30 days</u> to complete my records, which can be extended by a request in writing.**

I fully understand and accept the terms of this authorization:

_____ _____

Signature of Patient or representative | Date

_____ _____

Printed name of representative (if applicable) | Relationship/Authority

_____ _____

Witness (not required) | Date