☐ Rainelle Medical Center, Inc.
645 Kanawha Ave.
Rainelle, WV 25962
Phone: 304-438-6188
Fax: 304-438-7430

☐ Meadow Bridge Clinic
P O Box 120
Meadow Bridge, WV 25976
Phone: 304-484-7755
Fax: 304-484-6205

☐ Rupert Clinic
P O Box 128
Rupert, WV 25984
Phone: 304-392-1040
Fax: 304-392-2083

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____
Street Address: _____
City, State, Zip Code _____

PHI/MR# _____
Phone# _____
DOB: _____ S.S # _____

☐ **I request** _____ **release my Protected Health Information to Rainelle Medical Health Center.**

☐ **I authorize RAINELLE MEDICAL CENTER and its satellite clinics to release my Protected Information (PHI) to:** _____

The specific information to be released includes the following:

_____History & Physical
_____Staff/Progress Notes
_____Growth Records
_____Immunization Records
_____Other _____

_____Laboratory Studies
_____Radiology Report
_____Pathology Results
_____Medications

Special Instructions: _____

Date(s) of Treatment: _____ Reasons for Request/Disclosure: _____

HIV, Behavioral Health, and Substance Abuse Information contained within the records indicated above will be released through this authorization unless otherwise indicated below.

DO NOT RELEASE: _____HIV _____ Substance Abuse _____Behavioral Health/Psychiatric _____ Other _____

I understand the following:

- My health records will not be released by any facility or RMC unless my permission is granted by signature on this or the Consent/Permission To Provide Medical Services form (which grants permission to forward my PHI to obtain treatment by a referral physician).
- Only records specific to the purpose granted will be released.
- Although prohibited, it is possible my PHI may be unintentionally re-disclosed by the facility receiving my records; therefore, such information would no longer be protected by the HIPPA Privacy Rule.
- I am entitled to a copy of this completed authorization form.
- This authorization is valid for one year from the date of signature, unless a specific time frame of less than one year is documented herein: Specific time frame limitation, if any _____.
- I have the right to revoke this authorization at any time by sending a written request to the facility from which my PHI is being requested.
- My decision to revoke this authorization does not apply to any other release of PHI that has been previously approved or which may be necessary to obtain a referral to another physician.
- My decision to revoke this authorization may result in my insurance company refusing to pay for my medical care and I agree to be liable for payment of the claim.
- Photocopies – Federal and State laws indicate a reasonable, cost based fee may be charged for copies of health care records. Copies of my records provided to a referral physician for my continued care will be mailed at no charge.

Patient Signature: _____ Date: _____
or
Legal Representative: _____ Date: _____
(Indicate Authority/Relationship)

Witness: _____ Date: _____

Revised 05-10-05