THOMAS HEALTH
AN AFFILIATE OF WVUMedicine

TH Orthopedics on Chestnut Street
610 Chestnut Street
South Charleston, WV 25309
Phone: 304-767-7790
Fax: 304-766-7566

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Birth Date: _____ Social Security #:_____

Street Address: _____

City, State, & Zip: _____

Senders Information:		**Requestor's Information:**	
Dr:		Requestor's name (if not Patient)	TH Orthopedics on Chestnut Street
Street Address:		Street Address:	610 Chestnut Street
City, State, & Zip:		City, State, & Zip:	South Charleston, WV 25309
Phone/ Fax#:		Phone/ Fax#:	304-767-7790 (phone) 304-766-7566 (fax)

Is this a request for psychotherapy notes?

___ Yes, then this is the **ONLY** item you may request on **THIS** authorization.

___ No, then you may check as many items below as you need.

	All PHI in Record		Physician Orders		Demographics
	H & P		Laboratory		Rehab Services
	Consult Report		Imaging		Special Tests/Therapy
	Operative Report		Nursing Notes		Itemized Bill/Claims
	Progress Notes		Medication Record		Other

1. I acknowledge, and herby consent to such, the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, and AIDS information. _____ (initial here)
2. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (expect for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or a health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I will receive a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated. I also agree this authorization expires six (6) months after it is signed.

Signature:_____ Relationship to Patient: _____

Print Name: _____ Date: _____