



AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health care provider; the released information may no longer be protected by federal privacy regulation.

Patient's Name: Social Security Number: Date of Birth:

Persons/organization providing the information:

Persons/organization receiving the information:

Specific description of information (including date[s]):

Reason for release:

CHECK ONE

- Copy of medical records of St. Mary's Neurosurgery, LLC
Copy of medical records prior to St. Mary's Neurosurgery, LLC (specify dates above)
Copy of medical records prior to Tri-State Neuroscience Center, Inc. (specify dates above)
Other (please describe)

Physician's Name

The patient or patient's representative must read and initial the following statement:

- 1. I understand that this authorization will expire 90 days from the date signed.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

Signature of patient or patient's representative (Form must be completed before signing)

Date

Printed name of patient's representative: Relationship to the patient:

* YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*
St. Mary's Medical Center Correspondence/Release of Information (304) 526-1205
2900 First Ave - Huntington, WV - 25702
Office Hours: Monday - Friday, 9:30a.m. - 4:00p.m.
Closed Daily from Noon - 1:00p.m. and Closed Holidays
WWW.ST-MARYS.ORG