Pleasant Valley Hospital
2520 Valley Drive • Point Pleasant, WV 25550
Phone: 304.675.4340, ext. 1355 **Fax:** 304.675.5168

Authorization Form for Disclosure of Protected Health Information

I authorize _____ to release Protected Health Information regarding the treatment, hospitalization, and/or outpatient care of:

Patient Name	Date of Birth	Social Security #	Telephone #
_____	_____	_____	_____

Covering the period(s) of healthcare:

From (date) _____ to (date) _____

From (date) _____ to (date) _____

This information is to be released to: _____

Name and Address

For the purpose of: _____

The following information is to be released:

History/Physical	☒	X-ray Report	☒	Discharge Summary	☒	Operative Report	☒
Pathology Report	☒	Clinical Report	☒	Lab	☒	Emergency Dept.Report	☒

Other (specify) ☒ _____

I specifically authorize the release of any and all information relation to (check if applicable):

___ Acquired Immunodeficiency Syndrome (AIDS) or infection with (Human Immunodeficiency Virus)

___ Psychiatric care ___ Treatment for alcohol and/or drug abuse

I understand that I generally may revoke this authorization at any time by notification **in writing** to: Pleasant Valley Hospital, Attn: Privacy Officer 2520 Valley Drive, Pt. Pleasant, WV 25550 of my intent to revoke this authorization, except that if I do notify Pleasant Valley hospital in writing of my intent to revoke this authorization, such revocation will not have any effect on my actions by Pleasant Valley Hospital taken before revocation. **All written revocation should be dated and signed**. Unless otherwise revoked, this authorization will expire 90 days after the date of signature.

Information used to disclose pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Pleasant Valley Hospital will not condition my treatments, payment, enrollment or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____
Authorization Signature (relationship or authority to authorize disclosure) **Date**

_____ _____
Witness **Date**