Unity Family Health Care
Sarita Bowers, FNP David Bowers, FNP
1644 Valley Rd. Ste A
Berkeley Springs, WV 25411
Ph: 304-500-2567 Fax: 304-500-2748

Medical Record Release of Information Authorization

Be sure to complete all fields so that you can be contacted with any issues that may arise. Failure to provide any of these fields will result in delays of the delivery of the medical information.

Patient Name:________________________________ **Date of Birth:** _____ / _____ / _________ **SSN #: (last 4)-** ______________

AKA or Maiden Names: ____

Patient Address: ____

City: ____**State:** _____ **Zip Code:** ____________ **Phone:** (___) _____ - ________

Email: ______________________ @ ____________________________. ________ **Fax:** (___) _____ - ________

Doctor you would like information from:

Doctor or Facility Name: ____________________________________

Address: ____

City: ____

State: _____ **Zip Code:** __________ **Fax:** (___) ______ - _________

Where you would like Medical record sent:

Doctor or Facility Name: Unity Family Health Care

Address: 1644 Valley Rd. Ste A

City: Berkeley Springs

State: WV **Zip Code:** 25411 **Fax:** (304) 500 -2748

Dates of Service: - From: __________ \\ __________ **- To:** __________ \\ __________

Specific Information:____

Purpose of Disclosure: Transfer of Care or Specialist Notes for PCP Information

You MUST agree or disagree to each of the following. Please be advised that disagreeing to any of the following may result in portions of your medical file being withheld from the response

Unless otherwise revoked, this authorization will expire six months from the date from which it was originally signed or on the following date ____/_____/_________

My evaluation, diagnosis, and/or treatment relating to the conditions listed below may be released to the requestor identified above for the following type of records unless otherwise indicated.

Agree ______ Disagree _____ - AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
Agree_______ Disagree______- Psychiatric care and/or psychological assessment
Agree ______ Disagree _____ - Treatment for alcohol and/or drug abuse.
Agree ______ Disagree _____ - Mental Health Treatment

Failure to complete this section will automatically imply a declination of the above

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above-named facility authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization. I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure continued treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization. **Requests cannot be processed without proper authorization. Minors must have a parent signature. Individuals requesting records on deceased or adult patients must provide the required Power of Attorney or other supporting legal documents.**

____ Date: _________________
Signature of Patient or Authorized Representative