PATIENT AUTHORIZATION FORM

To: ____
____
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I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described.

Description of the specific information to be used or disclosed:

- ❑ Office Notes
- ❑ History & Physical
- ❑ Hospital Summary
- ❑ Operation Reports
- ❑ Pap Smear
- ❑ Lab
- ❑ Pathology
- ❑ Ultrasounds
- ❑ X-ray
- ❑ Mammograms
- ❑ Other

Person or entity requesting the information and authorized to make the requested use or disclosure:

Dr. Capelle, 3496 University Avenue, Morgantown, WV 26505
Phone: 304-599-7075 Fax: 304-581-6800

Recipient of the information: ______________________________

The information is being requested for the following purpose(s):

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The authorization shall remain in effect from the date signed below until ______________ (expiration date or event)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).
- ❑ If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name:____________________________ Signature:______________________________
Social Security Number: ____________________ D.O.B. __________
Relationship to Patient
(if signed by personal representative of Patient):_____________________________ Date:__________