AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Name:______________________________ Date of Birth:______________
Address:____________________City:______________State: _______Zip:__________
Phone:____________________

The undersigned hereby authorizes and requests from:

Name:________________________ Phone #:____________Fax#:____________
Address:______________________ City:______________ State:_____ Zip: ________

To Provide to:

Name: Thomas/Hunter/Naegele/Cottle Phone #: (304) 343-4177 Fax #:(304) 3430875
Address: 830 Pennsylvania Ave. Ste 402 City: Charleston State: WV Zip: 25302

Please indicate what specifically is to be released:
( )Entire Medical Record ( )Mammography ( )Laboratory Tests
( )Operative Reports ( )Pathology ( )Papsmear
( )Other:____

Covering record for time period from ___________to______________ and hereby release Thomas, Hunter and Associates, PLLC from all legal liability that may arise from further disclosure of said records.

Information is being released for the following purpose:
( )Changing Physicians ( )Consultation/Second Opinion ( )Continuing Medical Care
( )Other:____

I understand that these medical records may or may not contain information pertaining to psychiatric counseling or testing, alcohol or drug abuse counseling or testing, and/or HIV testing. I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) as stated above. This authorization will remain in effect for a period of ninety(90) days from the date stated below, unless revoked in writing by the person to which it pertains to the staff of Thomas, Hunter and Associates, PLLC.

Patient/Legal Guardian Signature:______________________________Date:______________

Witness:____Date:______________