AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Name:_____ Date of Birth:_____
Address:_____City:_____State: _____Zip:_____
Phone:_____

The undersigned hereby authorizes and requests from:

Name: **Thomas/Hunter/Naegele/Cottle** Phone #: (304) 343-4177 Fax#: (304) 343-~~5271~~ 0875
Address: **830 Pennsylvania Ave. Ste 402** City: **Charleston** State: **WV** Zip: **25302**

To Provide to:

Name:_____Phone #:_____Fax #:_____
Address:_____City:_____State:_____Zip:_____

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:_____