Clarksburg Medical Center

Authorization for Release of Medical Information

(Month/day/year)

Patient's name: _____ Date of Birth ____/____/____

Address: _____

City/State/Zip Code: _____

SS# _____ Patient's Phone #: ( )_____-_____

Date of Request: _____ **Date Needed:** _____

I authorize Clarksburg Medical Center

To release information to:

_____
Name of provider or Facility

_____
Address

_____
City, State Zip Code

_____
Phone # including area code

_____
Fax # including area code

OR

I authorize Clarksburg Medical Center

To obtain information from:

_____
Name of provider or Facility

_____
Address

_____
City, State Zip Code

_____
Phone # including area code

_____
Fax # including area code

Purpose for this request (check one)

- o Health care
- o Insurance Coverage
- o Personal
- o Transfer of Care
- o Other

Types of records requested:

___ Immunization history
___ Administered by CMC only
___ Includes records submitted to CMC
___ All medical records to a specific illness or injury:
_____

- o Specific illness/injury
- o Dates of treatment
- o Treatment Summary

Specific information

___ Procedure report

___ X-ray reports

___ History & physical

___ Physical Therapy

___ Lab test results

___ Other (please describe):

Signature of patient or Representative:

_____

Relationship to patient (if requestor is not the patient)

_____

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