Eastern Panhandle Free Clinic
1212 North Mildred Street
Ranson, WV 25438
304-724-6091

GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, patient of the Eastern Panhandle Free Clinic ("Provider"), understand that my signature below gives Provider permission, to the extent necessary, to use my medical records, and to provide access to my medical records, while and after I am treated by Provider, for the reasons that follow:

1. For the purpose of providing treatment to me.
2. For the purpose of Provider's "health care operations." This last category includes such things as internal quality assessment activities, contacting other health care providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolution of internal grievances and the provision of legal and auditing services.
3. For the purpose of other health care providers' "health care operations," to the extent that they have a treatment relationship with me.

I understand that my permission allows Provider to transmit permissible information through any means that is reasonably secure, including via e-mail, assuming that reasonable protective measures are taken to preserve the confidentiality of the information.

I understand that I may revoke this authorization at any time, but that Provider may refuse to give me further treatment if I do so.

I understand that I have the right to request that Provider restricts how my medical information is used. If I wish to request a restriction, I will initial here: _______. In this case, Provider will give me a separate form (FORM 4) to fill out, which will also be used for Provider to indicate whether or not Provider agrees to the requested restriction.

I understand that I have a number of rights identified below (and listed more fully on the Patient Notice provided to me by Provider):

- The right to review, and copy, my medical records
- The right to request the amendment (changing) of my medical records
- The right to grant or deny access to my records to others
- The right to decide how information from my records will be conveyed to others
- The right to complain about how my records are handled, to the Secretary of the U.S. Department of Health and Human Services, and to Provider
- The right to revoke, in writing, any consent that I provide for access to my records

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- The right to authorize Provider to give information about my care to relatives or close friends, to the extent of their involvement with my care or payment
- The right to review a record of access to my medical records

I understand that I have the right to either grant or deny access to my medical records, and that my specific written permission will be sought if access is requested for any reason not set forth above, or, in most cases, for the release of psychotherapy notes.

The provider may decide to change some of the above-stated policies, and I understand that I will be given a revised Notice if this occurs.

____

Name of Patient (Printed)

____

Signature of Patient   Date

____

Witness   Date