Shenandoah Valley Medical System, Inc.
Shenandoah Community Health Center
99 Tavern Road
Martinsburg, West Virginia 25401
Phone 304-263-4999 Fax 304-596-2242
www.svms.net

AUTHORIZATION TO RELEASE or OBTAIN CONFIDENTIAL INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____ Last 4 digits S.S.N._____

_____ Phone:_____

I hereby authorize: (Name)_____

(Address)_____

(Telephone#)_____ (FAX #)_____

to release to: (Name) Kristina Maciunas MD

(Address) Healing Ways Healthcare PLLC
PO Box 1683
Shepherdstown, WV 25443

(Telephone #)_____ (FAX #)_____

the following medical records:

[ ] Medication List	[ ] Last Office Note	[ ] Laboratory Results	[ ] Mammogram
[ ] Well Child Visit	[ ] Problem Summary List	[ ] X-Ray/Imaging Reports	[ ] Pap Test
[ ] Immunization Record	[ ] Consultation Reports	[ ] Other_____	

For date(s) of service (only):_____

Please list specific date or range of dates/years

I understand that the following medical information requires specific authorization (initials required)

_____Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infections
_____Behavioral/Mental Health/Psychotherapy Records & Medication
_____Treatment for alcohol and/or drug abuse

The purpose for release of the above information is: ___Continued Care ___Insurance ___Legal ___Other (specify):_____

- I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication to Shenandoah Valley Medical System, Inc. This consent will expire in one year from the date signed, unless otherwise stated as follows:_____
- I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed and my treatment will not be affected by my refusal to sign this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the Health Insurance Portability and Accountability Act (HIPAA).
- A copy of the authorization has been _____accepted _____rejected by the patient/representative.

_____ _____ _____

Signature of Patient or Representative | Relationship to Patient | Date signed

Information Released by:_____ Date:_____