



P E N D L E T O N
Community Care, Inc.

Patient Authorization for Use and/or Disclosure
Of Protected Health Information Request

I request and here by authorize: PCC/NFC/HHC _____

To release information from the record of:

Patient Name (print full name): _____

Social Security Number: _____ Date of Birth: _____

As described to: _____
Facility/Person to Receive Records

To disclose the following health care information (check all that apply):

- Pap Test Results Dates: _____ Immunizations Dates: _____
 Mammogram Results & films/CD Dates: _____ Labs Dates: _____
 Colonoscopy Results Dates: _____ Eye Exam Results Dates: _____
 Other: _____

Format patient would like to receive records: Paper Disc Fax

Patient Signature: _____ Date: _____

Please Send Results To: Self or Authorized Representative

- | | | |
|---|---|--|
| <input type="checkbox"/> Pendleton Community Care
PO Box 100
Franklin, WV 26807
Phone: 304-358-2355
Fax: 855-332-1388 | <input type="checkbox"/> Harman Health Center
PO Drawer 14
Harman, WV 26270
Phone: 304-227-4134
Fax: 855-332-1388 | <input type="checkbox"/> North Fork Primary Care
PO Box 101
Riverton, WV 26814
Phone: 304-567-2101
Fax: 855-332-1388 |
|---|---|--|

Faxed or Delivered by: _____ Date: _____