WVU Physicians of Charleston

Health Information Management
3110 MacCorkle Avenue, SE
Charleston, WV 25304
Phone: (304) 341-1550
Fax: (304) 341-1549

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: ____ **DATE OF BIRTH:** ___________________
[Please print full name]

LAST 4 SSN: ____________ **DAY PHONE:** _________________________ **OTHER NAMES USED:** _____________________________

Date(s) of Service Requested: ____

☐ Office Visit Notes ☐ Pathology Reports
☐ X-rays or Imaging Report(s) ☐ Immunization Records
☐ Laboratory Results ☐ Other (be specific): ____

Method of Release: **Complete mailing address REQUIRED Incomplete forms will be returned to requester.**

Person/Facility to Receive Information (must be specific): ____

Mailed to: ***STREET:*** ____ ***CITY:*** ___________________ ***STATE:*** ____ ***ZIP:*** _______

☐ **Fax Number:** ___________________________________ **** WVUPC HIM Department will mail disc for records >40 pages. ****

☐ **Delivered to patient email address:** ____
**West Virginia University Physicians of Charleston (WVUPC) is not responsible for the potential risks associated with unsecured email transmission of your protected health information.

Purpose of Disclosure: (If records are being delivered to patient directly this section can be blank)

☐ Continuity of Care ☐ Insurance ☐ Litigation ☐ Worker's Compensation
☐ Disability Determination ☐ Personal ☐ Other (Please specify): _________________________________

Authorization to Release Information:

1. I understand that, by signing this Authorization to Disclose Health Information, I am giving my permission for WVU Physicians of Charleston to disclose all of the records I have specified for release to the designated recipient. Unless indicated below, I specifically authorize the release to include such confidential health care information as may be contained in the records I have designated for release and which may relate to behavioral or mental health services, treatment for alcohol and drug abuse, sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV).

****Check below any such categories of records that you are NOT authorizing WVUPC to release:**

☐ Behavioral/Mental Health ☐ Sexually Transmitted Diseases
☐ Alcohol/Drug Abuse ☐ AIDS ☐ HIV

NOTE: ** Psychotherapy Notes (If this authorization is for the disclosure of Psychotherapy notes as defined by HIPAA, then it cannot be combined with the authorized release of other health information. A separate authorization is required.)**

Other Special Instructions, if any: ____

2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment, payment, enrollment in a health plan, or eligibility for benefits. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department at 304-341-1550.

3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to: Director of Health Information Management, WVUPC, 3110 MacCorkle Avenue, SE, Charleston, West Virginia 25304. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 180 days from the date of signature. If applicable, insert another date or event of expiration: ______________________________

4. I understand that I will be given a copy of this authorization form upon request. **Furthermore, I understand that copying charges will be applied according to State/Federal Law. This current rate is $25.00 per hour cost based fee, pre-payment MAY BE required. All requests are processed within 30 DAYS of receipt as permitted by State/Federal Law**.

Signature of Patient or Legal Representative____
DATE

If signed by legal representative, relationship to patient: ____