WVU Physicians of Charleston

Health Information Management
3110 MacCorkle Ave SE
Charleston WV, 25304-1299
Phone Number: 304-341-1550

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME (Print full name): _____ **DOB (Required):** ____/____/____

Last 4 SSN: _____ **DAY PHONE:** _____ ***Other Names Used:*** _____

Information Requested: (Select at least 1 choice from options below)

☐ Entire Record
☐ Office Visit Notes: Date(s) _____
☐ Radiology Reports: Date(s) _____
☐ Laboratory Results Date(s) _____
☐ Pathology Reports: Date(s) _____
☐ Immunization Records: Date(s) _____
☐ Other (be specific): _____

Method of Release: (Mailing address required)

Person/Facility to Receive Information: _____

STREET: _____ ***CITY:*** _____ ***STATE:*** ____ ***ZIP:*** _____

☐ **Health Care Provider Fax Number (Continuity of Care only):** _____

☐ **Email Address:** _____ *****WVUPC is not responsible for the potential risks associated with unsecured email transmission of your protected health information.**

Purpose of Disclosure: This section is not required if records are being delivered to the patient requesting Information.

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

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
☐ Alcohol/Drug Abuse
☐ Sexually Transmitted Diseases
☐ AIDS
☐ HIV

NOTE: ** Psychotherapy Notes (If you are seeking the release of Psychotherapy Notes as defined by HIPAA, then you must execute a separate authorization as required by the Health Insurance Portability and Accountability Act (HIPAA). Please obtain an Authorization to Release Psychotherapy Notes form online at http://www.wvupc.org/compliance/Records-Requests.aspx or contact the WVUPC HIM department.)**

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 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. As of 6/2014, WV State Legislation permits a $25.00 per hour cost based fee.

Signature of Patient or Legal Representative_____
DATE

If signed by legal representative, relationship to patient: _____