WVU Physicians of Charleston

AA Info Services
PO Box 4489
Charleston, WV 25364
Phone: (304) 341-1550
Fax: (304) 341-1549

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

**Please complete this form and return to WVUPC Health Information Management by:**

**Fax: (304) 341-1549** **Mail to: AA Info Services**
**Email: (records@aainfoservices.com)** **PO Box 4489**
**Charleston WV, 25364**

**West Virginia University Physicians of Charleston (WVUPC) and/or AA Info Services is not responsible for the potential risks associated with unsecured email transmission of your protected 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
- ☐ X-rays or Imaging Report(s)
- ☐ Laboratory Results
- ☐ Pathology Reports
- ☐ Immunization Records
- ☐ 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:** _____

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**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
- ☐ Alcohol/Drug Abuse
- ☐ Sexually Transmitted Diseases
- ☐ 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: AA Info Services, PO Box 4489, Charleston, West Virginia 25364. 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 in WV is $20.00 processing fee plus .20 per page fee up to $150, pre-payment MAY BE required. All requests are processed within 30 DAYS of receipt as permitted by State/Federal Law**. All payments to be invoiced and collected by AA Info Services.

**Signature of Patient or Legal Representative**_____ **Patient signature not required for records to be sent directly to another health care provider/facility.

DATE

If signed by legal representative, relationship to patient: _____

*Updated 4/2022*