



# WVU Healthcare

## Authorization for Release of Protected Health Information

Patient Name: \_\_\_\_\_ PHI / MR # \_\_\_\_\_

Address: \_\_\_\_\_ Phone # : \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

I authorize:

\_\_\_\_\_  
*Name/Physician/Facility/Agency                      Street Address/PO Box Number                      City, State and Zip                      Phone/Fax*

To release my Protected Health Information (PHI) to:

**WVU Healthcare, 171 Taylor Street, Harpers Ferry, WV 25425**  
**Phone: (304) 535-6343    Fax (304) 535-6618**

The specific information to be released includes the following:

- |   |   |
|---|---|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Laboratory Studies |
| <input type="checkbox"/> Staff/Progress Notes | <input type="checkbox"/> Radiology Report   |
| <input type="checkbox"/> Growth Records       | <input type="checkbox"/> Pathology Results  |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Other _____        |

**Special Instructions:**  
\_\_\_\_\_

Date(s) of Treatment \_\_\_\_\_ Reason for Request/Disclosure: \_\_\_\_\_

**HIV, Behavioral Health, and Substance Abuse information** contained within the records indicated above will be released through this authorization unless otherwise indicated below.

**DO NOT RELEASE:**  HIV     Substance Abuse     Behavioral Health/Psychiatric     Other: \_\_\_\_\_

**I understand the following:**

- My health record(s) will not be released or obtained by WVU Healthcare unless permission is granted by my signature on this authorization.
- Only the records checked above will be released for the above-stated reason(s).
- Although prohibited, it is possible that my PHI may be re-disclosed by the facility receiving my records, therefore, UHA has no responsibility or liability as a result of the re-disclosure, and such information would no longer be protected by the HIPAA Privacy Rule.
- I am entitled to a copy of this completed authorization form.
- This authorization is valid for one year from the date of signature, unless a specific timeframe less than one year is documented:
  - Specific timeframe for validity: \_\_\_\_\_
- I have the right to revoke this authorization at any time by sending a written request to:
  - WVU Healthcare, 171 Taylor St, Harpers Ferry, WV 25425, Attn: Director of Health Information Management.
- By revoking this authorization,
  - My decision to revoke the authorization does not apply to any release of PHI that may have taken place prior to the date of the revocation request.
  - My decision to revoke the authorization may result in my insurance company not being able to pay for my medical care and I may be liable for payment of the claim.
- Photocopies are provided by a contractual copy service that will invoice the requestor directly. Federal and state laws indicate that a reasonable, cost-based fee may be charged for copies of health care records. Copies of my records that are provided for my continued care will be mailed to my physician at no charge.

**Patient Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

OR

**Legal Representative:** \_\_\_\_\_ **Date** \_\_\_\_\_

(Signature/Authority/Relationship)

**Witness :** \_\_\_\_\_ **Date** \_\_\_\_\_