WVUMedicine

Operated by West Virginia University Hospitals, Inc.
Morgantown, WV 26506
CH012 (R 3/16)

Chestnut Ridge Hospital/Behavioral Medicine/Student Health

Authorization for Release of Confidential Information

Date: _____/_____/_____

Patient Name: _____

Address: _____
(City) (State) (Zip)

Phone: _____ Birthdate: _____ S.S.N. _____

This information is to be:
☐ Mailed ☐ Hand carried by _____ ☐ Other_____
(Photo ID required)

I, the undersigned, hereby authorize West Virginia University Healthcare to provide the following person:

_____
Identity of Third Party (Name/Organization to whom info is to be given)

_____
Street (City) (State) (Zip)

_____
Phone Fax

_____ History and Physical
_____ Summary
_____ Staff/Progress Notes
_____ Intake Evaluation
_____ Laboratory Studies

_____Immunization Records
_____Psychological testing
_____Verbal Communication
_____Other _____

Special Instructions:

Special Instructions

_____

Other (Specify)

_____

Covering record for time period from _____ to _____ and hereby release WVUH from all legal liability that may arise from further disclosure of said records.

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_____

INPATIENT OUTPATIENT
☐ Chestnut Ridge Hospital
☐ Student Health

OUTPATIENT
☐ Behavioral Medicine ☐Family Medicine
☐ Eye Institute

The requested information to be released shall consist of duplicated medical records or concerning my treatment in the Chestnut Ridge Hospital.

_____ _____/_____/_____ _____
Signature of Patient (age 10 and up) Date Time

_____ _____/_____/_____ _____
Signature of Legal Representative Relationship/Proof Date Time

_____ _____/_____/_____ _____
Signature of Witness Date Time

I UNDERSTAND THE FOLLOWING:

- My health record(s) will not be released or obtained by UHA unless permission is granted by my signature on this authorization.
- Only the record(s) checked above will be released for the above will be released for the above stated reason(s).
- Although prohibited, if as 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 rules.
- I am entitled to a copy of this completed authorization form.
- This authorization is valid for one year form the date of signature, unless a specific time frame less than one year is documented:
    - Specified time from for validity: _____
- I have the right to revoke this authorization at any time by sending a written request to:
    - West Virginia University Hospitals
      Attn: Director of Health Information
      PO Box 8049 Morgantown, WV 26506
      PH: 304-598-4110 FAX: 304-598-4129
- 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 revocation request.
    - My decision to revoke the authorization may result in my insurance company not being able to pay for the medical care and I may be liable for payment of the claims.
    - WVUH cannot require me to sign the authorization in order to receive treatment.