WVU Medicine

WVU Hospitals and University Health Associates
Morgantown, WV 26506

AUTHORIZATION FOR RELEASE OF INFORMATION

FORM CNST 614 (R08/2016)

Date:_____ MRN _____

Authorization for Release of Information

1 . Patient name _____
(Last) (First) (Middle Initial)

Address_____
(City) (State) (zip)

Phone_____Birthdate_____SSN_____ (to be used if unable to find patient with name or date of birth)

2. This information is to be used for the purpose of:
☐ Self ☐Insurance ☐ Workers Comp ☐Disability ☐ Attorney ☐ Physician or other Health Care Provider- (required to complete 3 A)

3. This information is to be:
☐Mailed to Patient ☐ Hand Carried by _____ ☐ Will Pickup Date _____ Time _____
(Photo ID Required) (Allow 24 hours for Continue care. 7-21 days for other)

☐ Mail to Physician or Health Care Provider (all information is to be completed) ☐ Release to MyWVUChart ☐Fax to:_____

3A. _____
(Name of Facility)

_____
(Complete Mailing Address) (City) (State) (zip)

_____
(Phone Number required) (Fax number required)

4. Release the following with photo static copies regarding my treatment: Required items must be checked: Medical Records provided on a DVD

_____ History and Physical _____ Cancer Center _____ X-Ray Reports (Reports only) _____ CID (Disc of Images)

_____ Physical Therapy _____ Operative Report _____ Pathology Reports _____ Office Visits

_____ Emergency Dept. _____ Laboratory Results _____ Immunization Record _____ Discharge Summary

_____ HVI (Heart and Vascular Institute)

Other (specific instructions) _____

Covering record time period from _____ to _____ and hereby release WVUH from all legal liability that may arise from further disclosure of said records. (Required - Do not Date Ahead)

HIV - BEHAVIORAL HEALTH - DRUG ALCOHOL - PREGNANCY INFORMATION contained within the records indicated above will be released through this authorization unless otherwise indicated below. **(Any records containing any of this info requires signature from age 14 and older to sign for release of records)***

Do not release: _____ HIV _____Substance Abuse which includes (Alcohol - Drug Abuse) _____ Pregnancy Test
_____ Behavioral Health/Psychiatric _____Sexually Transmitted Disease _____Other (Please List)_____

**** Do not use this release for Chestnut Ridge or Chestnut Ridge Behavioral Medicine Records***

PLEASE READ: As of June 6, 2014, person(s) and companies requesting copies of healthcare records and radiology images for personal use will be charged according to West Virginia code 16-29-2 (2014). Requests will be pre-billed and payment received before records and images are released. West Virginia Code states that a health care provider may charge reasonable labor cots of up to $25.00 per hour plus the costs of postage for copies of healthcare records. Copies of your records mailed to your physician will be provided at no charge.

_____ Date/Time_____
(Signature of Patient Age 14 and up-Required)

_____ Date/Time_____
(Signature of Legal Representative) (Relationship/Proof)

My health record(s) will not be released or obtained unless permission is granted by my signature on this authorization.

Only the record(s) checked above (front page) will be released for the above will be released for the above stated reason (reasons).

Although prohibited, if as possible that my PHI may be re-disclosed by the facility receiving my records, therefore, WVUH 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 from 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 Healthcare, PO Box 8049 Morgantown, WV 26506
Attention: Director of Health Information

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

This authorization may be revoked at any time by the patient. The revoking of this authorization shall not cancel any prior action that has transpired. This authorization shall remain valid for the production of specified records until the following date _____ or a period of 1 year from the date of form completion.
A new authorization will be required for any new visits to WVUH that occur after the date of this authorization. Authorizations cannot be given for future visits.

NOTE: ADDITIONAL INFORMATION REGARDING HAND-CARRIED RECORDS OR MEDICAL INFORMATION INCLUDING AIDS, SEXUALLY TRANSMITTED DISEASE, HIV RELATED DISEASES, DNA SCREENING, BLOOD ALCOHOL CONTENT, ALCOHOL/SUBSTANCE ABUSE, ADOPTION AND / OR PSYCHIATRIC RECORDS ARE REQUESTED ON THE REVERSE SIDE OF THIS SHEET.

Health Information Management Department

Requests can also be sent via email rather than faxing or mailing the release. Please send requests to WVUHROIREQUEST@wvuhealthcare com

Ruby Memorial Hospital West Virginia University Children's Hospital Jon Michael Moore Trauma Center
PO Box 8049 Medical Center Drive, Morgantown, WV 26506-8049 PHONE: 304-598-4109 FAX: 304-598-4129

AUTHORIZATION FOR PERSONAL REVIEW OF MEDICAL RECORD

I request that I be permitted to review my medical record. I understand that any amendments can be requested by doing so on the Patient Amendment Form, not on the original chart. I have provided one form of Identification.

Name: _____ ID _____ Date/Time _____
(Last, First, Middle I) (Driver's License)

Signature: _____ Phone(required) _____
(Patients Signature)

You will be notified by phone for appointment time to view medical records:
[I understand that any medical information released by you pursuant to this authorization will be accompanied by the]
[following language in accordance with federal laws: This information has been disclosed to you from records whose]
[confidentiality is protected by state and federal law (42C.F.R. Part 2). State laws prohibits you from making any]
[further disclosure of the information without the specific written authorization of the person to whom it pertains]
[or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT]
[sufficient for this purpose.]