WVU Medicine

WVU Hospitals and University Health Associates
Morgantown, WV 26506

AUTHORIZATION FOR RELEASE OF INFORMATION

CNSTS 614 (R 04/2018)

Date: _____

Do you have a MyWVUChart account? Yes _____. If No, Email Address _____

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:
☐ Insurance ☐ Workers Comp ☐ Disability ☐ Attorney ☐ Military
☐ Physician or other Health Care Provider ☐ Self

3. This information is to be: **(only select ONE option)**
☐ Release to MyWVUChart ☐ Email to patient ☐ Email/Mail to Physician –(required to complete 3A)

(Photo ID Required) (Allow 24 hours for continuing care. 7-21 days for other request types)
(All information is to be completed)

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: Require items must be checked: Medical Records provided on a CD (viewed by computer): **(please only mark the options that you know received treatment for while a patient.)**

_____ Office Visits _____ Cancer Center _____ X-Ray Reports (Reports only) _____ CD (Disc of Images)
_____ Physical Therapy _____ Operative Report _____ Pathology Reports _____ History and Physical
_____ Emergency Dept. _____ Laboratory Results _____ Immunization Record _____ Discharge Summary
_____ HVI (Heart & Vascular Institute)

Other (specific instructions) _____

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

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 July 6, 2017, 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 (2017). 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 a $20 search fee along with 40 cents per page for paper records or 20 cents per page for electronic documentation plus the costs of postage for copies of healthcare records. Our standard of delivery is CD electronic format for all medical records requests. The search fee will be waived for patients requesting records. Please allow up to 30 days for processing. Copies of your records mailed to your physician will be provided at no charge.

_____ Date/Time _____
(Signature of Patient Age 10 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.
- 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 PHYCHISTRIC 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@WVUMEDICINE.ORG

JW Ruby Memorial Hospital / WVU Medicine
PO Box 8049 Morgantown, WV 26506-8049 PHONE: 304-598-4110 FAX: 304-598-4129

AUTHORIZATION FOR PERSONAL REVIEW OF MEDICAL RECORD