WVU Medicine
UNITED HOSPITAL CENTER

MRN_____

327 Medical Park Drive
Bridgeport, WV 26330

HIM ROI AUTHORIZATION (REV. 12-13-17)

Authorization for Release of Information

1. Patient name _____
Last First Middle Initial

Address_____
City State Zip

Phone_____ Date of Birth_____ SSN_____

2. This information is to be used for the purpose of:

___Personal ___Insurance ___Workers Comp ___Disability ___Attorney ___Military ___Physician or other Health Care Provider

3. This information is to be (only select ONE option):

_____Mailed _____Hand Carried _____Mailed or faxed to Physician or Health Care Provider

3A. _____
Name of Recipient

_____
Complete Mailing Address City State Zip

_____
Phone Number Fax number

4. Format: _____ Paper _____ Electronic Media (CD/DVD) _____Diagnostic Imaging CD (DICOM format) _____MyWVUChart

5. Release the following with photo static copies regarding my treatment:

____Discharge Summary ____History & Physical ____Consultation ____Operative Report ____Emergency Dept. ____ Office visit(s)

____Radiology Report ____Laboratory Report ____Pathology Report ____EKG ____Immunization Record ____Entire Chart

Other (please specify) _____

5A. Indicate which facility/office records are to be released from (check <u>only</u> what applies):

___UHC only ___ENT/Audiology ___Family Medicine ___Gastroenterology ___General Surgery ___Home Health/Hospice

___Infusion Center ___Internal Medicine ___Oncology Hematology ___Ophthalmology ___Orthopedics & Sports Medicine

___Plastic Surgery ___Radiation Oncology ___Rheumatology ___Thoracic Surgery ___United Rehab ___Urology ___UTCC

___Wound Care Clinic

Other (please specify) _____

6. Covering record time period from _____ **to** _____

I hereby release UHC from all legal liability that may arise from 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 includes alcohol/drug abuse) _____ Pregnancy Test
_____ Behavioral Health/Psychiatric _____Sexually Transmitted Disease _____Other (Please List) _____

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). Copies of your records mailed to your physician will be provided at no charge.

_____ Date_____
Signature of Patient

_____ Date_____
Signature of Legal Representative Relationship

- 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 stated reason (reasons).
- Although prohibited, if as possible that my PHI may be re-disclosed by the facility receiving my records, therefore, UHC 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 180 days from the date of signature.
- I have the right to revoke this authorization at any time by sending a written request to:
  United Hospital Center, 327 Medical Park Drive, Bridgeport, WV 26330
  Attention: 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 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.
  - UHC 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 for 180 days. A new authorization will be required for any new visits to UHC 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 Contact Information

United Hospital Center, Attn: Health Information Management Dept. Release of Information Office, 327 Medical Park Drive, Bridgeport, WV 26330

Phone: 1-681-342-1740, option 1

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.