



West Virginia University
Physicians of Charleston

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name of Patient: _____ SS No. _____
Address: _____ Date of Birth: _____
_____ Phone: _____

I, the above-referenced patient (or the patient's legal representative, if applicable) authorize my physician(s) at WVU Physicians of Charleston (WVUPC) to disclose my health information as identified below to the following: (insert name/address of individual or entity to whom WVUPC may release information and/or records) _____

The purpose of this authorized disclosure is: _____

By initialing the space(s) below, I specifically authorize the disclosure of the following health information and/or records relating to my medical care from (insert approximate dates of service) _____ to _____:

- | | |
|--------------------------------|---|
| _____ History/Physical reports | _____ Radiology reports |
| _____ Staff/Progress notes | _____ Laboratory reports |
| _____ Immunization records | _____ Pathology reports |
| _____ Billing statements | _____ Emergency and urgent care records |

Special instructions, if any: _____

**** The following items must be initialed to be included in the disclosure of health information:**

_____ * HIV/AIDS related health information and/or records

_____ * Mental health information and/or records

_____ * Genetic testing information and/or records

_____ * Information and/or records relating to sexually transmitted diseases

_____ * Drug/alcohol diagnosis, treatment and/or referral information (Federal law requires a description of how much and what kind of information may be disclosed, and prohibits the re-disclosure of such information): _____

_____ * Psychotherapy notes (If this authorization is for the use/disclosure of psychotherapy notes as defined by HIPAA, then it cannot be combined with the authorized release of other health information. A separate authorization is required)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to: Privacy Officer, WVUPC, 3110 MacCorkle Ave., S.E., Charleston, West Virginia, 25304. Unless earlier revoked, this authorization will expire 180 days from its date of signing. If applicable, insert another date or event of expiration: _____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment in a health plan, or eligibility for benefits. Unless otherwise provided by law, I may inspect or copy any information to be used or disclosed under this authorization. I also understand that if the person or entity receiving this information is not a health care provider or health plan covered by the federal privacy regulations, the information being authorized for release may be re-disclosed and no longer protected by such laws.

I further understand that the person(s) I am authorizing to disclose my information may receive reimbursement for copying costs and related expenses for doing so.

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient