WVU Medicine

WEIRTON MEDICAL CENTER

Authorization for Release of Protected Health Information

I hereby authorize WVU Medicine Weirton Medical Center to release information from the record of:

Patient Name	Date of Birth	Social Security Number

As described below to: _____ _____

Facility/Person to receive records — Telephone

Street Address	City/State	Zip

Records are requested for the purpose of:

□ Continuing Treatment □ Legal Purposes
□ Personal Use □ Insurance
□ Other: _____

Type of records to be released and dates of service (check all that apply):

□ Inpatient _____ □ Outpatient Testing _____
□ Same Day Surgery _____ □ Emergency Visit _____

Specific information to be released (check all that apply):

□ Abstract Record*
□ Cardiac Testing
□ Consultations
□ Discharge Summary
□ Emergency Room Reports
□ History & Physical
□ Lab/Pathology Results
□ Medication Records
□ PT/OT/Speech
□ Progress notes
□ Radiology Report
□ Radiology Images
□ Operative Report
□ Other (specify)
_____
_____
_____

By signing this authorization form, I understand that:

*HIV/Mental Health/Drug & Alcohol information contained in parts of the records indicated above will be released unless otherwise noted:
*DO NOT RELEASE □ HIV □ Mental Health □ Drug & Alcohol

*I have the right to revoke this authorization at any time by sending a written request to the Health Information Management Department at 601 Colliers Way, Weirton, WV 26062. Revocation does not apply to information that has already been disclosed in response to this authorization.

*Unless otherwise revoked, this authorization expires 90 days from the date of signature.

*Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.

*Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Authorized Representative	Date	Print Name & Relationship to Patient

MRN _____ Account # _____
Released By _____ Date Released/Responded _____
Page Count _____

*Contains all dictated reports, cardiology testing results, laboratory results, and radiology results for the purpose of continuity of care.