**Instructions For Completing This Authorization Form:**

1.) Please read all content and **complete all shaded areas** of this authorization form before signing it.

2.) A legal representative must provide a copy of the legal document along with this authorization form, if it is not already in the medical record, to be permitted to sign on behalf of a patient who is unable to sign and the reason.*

3.) Please call the Medical Records Department if you have any questions.

**WHEN READY:** ☐ Mail ☐ Call ☐ Fax #: _____

☐ Email address: _____

WVU Medicine WHEELING HOSPITAL | WVU Medicine HARRISON COMMUNITY HOSPITAL

# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

**RETURN TO: Medical Records Department**

**WHEELING HOSPITAL**
1 Medical Park
Wheeling, WV 26003
Phone: (304) 243-3306
Secure Fax: (304) 243-5074

**HARRISON COMMUNITY HOSPITAL**
951 East Market Street
Cadiz, OH 43907
Phone : (740) 942-6271
Secure Fax: (740) 942-2749

**PATIENT'S NAME:** _____ **DATE OF BIRTH:** _____

**PATIENT'S ADDRESS:**
Street: _____ **TELEPHONE #:** _____
City, State, Zip Code: _____ **SOCIAL SECURITY #:** _____
(to be used if unable to find patient with name or date of birth)

**MAIDEN/OTHER NAMES:** _____

**I AUTHORIZE:** ☐ **Wheeling Hospital** ☐ **Harrison Community Hospital** ☐ **Other:** _____

**to release all information contained in my medical records, including alcohol and drug abuse records (if any); mental health and/or psychological service record (if any); information about serious communicable diseases and infections which include human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and AIDS-related complex (ARC); and social services records (if any) to individual(s) or organization(s) listed below under the conditions specified below:**

**Do not release:** ☐ Alcohol/Drug Abuse ☐ Mental and Behavioral Health/Psychiatric ☐ Pregnancy Test ☐ Social Services
☐ Sexually Trasmitted Diseases (HIV,AIDS,ARC,Others) ☐ Other, please list: _____

**1.) NAME OF PERSON(S) OR ORGANIZATION(S) TO WHOM DISCLOSURE IS TO BE MADE:**

☐ **Wheeling Hospital - Name/Unit:** _____ ☐ **Harrison Community Hospital - Name/Unit:** _____

Organization: _____
Name and/or Unit: _____
Street: _____
City, State, Zip Code: _____

**2.) SPECIFIC TYPES AND DATES OF MEDICAL RECORDS REGARDING TREATMENT TO BE DISCLOSED:**

☐ Patient's demographic information with dates of service (Facesheet)
☐ Cardiac Reports ☐ Physical Therapy Notes ☐ History and Physical ☐ Progress Notes
☐ Emergency Department Report ☐ X-Ray and Imaging Reports (reports only) ☐ Consultation Reports ☐ Entire Chart
☐ Lab and Pathology Reports ☐ Images on CD (disc) ☐ Discharge Summary
☐ Operative Report
☐ Other (specific instructions): _____

**Specify dates of hospitalization/treatment:** ☐ Most Recent, or ☐ Time period from _____ to _____

**3.) PURPOSE AND NEED FOR DISCLOSURE:**

☐ **Medical** ☐ **Personal** ☐ **Legal** ☐ **Insurance** ☐ **At the request of the individual** (including driver's license or Social Security card)

Is this request for purposes for supporting a Social Security claim or appeal? ☐ No ☐ Yes

If YES, is the requestor financially unable to pay full copying charges by reason of: ☐ Unemployment ☐ Disability
☐ Income below the federal poverty level ☐ Receipt of state federal income assistance

4.) **Consent will expire on:** _____ (One year from date of signature if not specified.)

5.) **I understand that I may revoke this authorization in writing at any time except to the extent that Wheeling Hospital or Harrison Community Hospital has already relied on this authorization.**

6.) **I understand that protected health information, once disclosed to others, may be re-disclosed to individuals or organizations not subject to HIPAA privacy standards and may no longer be protected by HIPAA.**

7.) **I understand that Wheeling Hospital or Harrison Community Hospital may not condition treatment on my completion of this authorization form.**

**X** _____ **Date:** _____

**SIGNATURE of Patient or Parent; or Legal Representative*, if patient is unable to sign:**

**Reason:** _____ **Relationship:** _____

**Witness, if patient signs "X" :** _____ **Date:** _____

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**TO BE COMPLETED BY HOSPITAL STAFF ONLY:**

**Verbal authorization received from/on behalf of patient by:** _____ **Date:** _____

**ROI IDENTIFICATION VERIFICATION, as needed:** ☐ **Photo ID** ☐ **Other (list):** _____ **Initials:** _____