University Health Associates
Harpers Ferry Family Med.
171 Taylor Street
Harpers Ferry, WV 25425
Phone: (304) 535-6343
Fax: (304) 535-6618

WestVirginiaUniversity
ROBERT C. BYRD HEALTH SCIENCES CENTER
EASTERN DIVISION

Authorization for Release of Protected Health Information

Patient Name:_____ PHI / MR #_____

Address: _____ Phone # :_____

Date of Birth:_____ SSN:_____

I authorize:

_____

Name/Physician/Facility/Agency *Street Address/PO Box Number* *City, State and Zip* *Phone/Fax*

To release my Protected Health Information (PHI) to:

University Health Associates, 171 Taylor Street , Harpers Ferry, WV 25425
Phone: (304)-535-6343 Fax: (304)-535-6618

The specific information to be released includes the following:

___History and Physical
___Staff/Progress Notes
___Growth Records
___Immunization Records
___Laboratory Studies
___Radiology Report
___Pathology Results
___Other_____

Special Instructions:

Date(s) of Treatment_____ Reason for Request/Disclosure: _____

HIV, Behavioral Health, and Substance Abuse information contained within the records indicated above will be released through this authorization unless otherwise indicated below.

DO NOT RELEASE: __HIV __Substance Abuse __Behavioral Health/Psychiatric __Other:_____

I understand the following:

- My health record(s) will not be released or obtained by UHA unless permission is granted by my signature on this authorization.
- Only the records checked above will be released for the above-stated reason(s).
- Although prohibited, it is possible that my PHI may be re-disclosed by the facility receiving my records, therefore, UHA has no responsibility or liability as a result of the re-disclosure, and such information would no longer be protected by the HIPAA Privacy Rule.
- 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 timeframe less than one year is documented:
  - Specific timeframe for validity: _____.
- I have the right to revoke this authorization at any time by sending a written request to:
  - University Health Associates,171 Taylor Street, Harpers Ferry ,WV 25425, Attn: 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 date of the revocation request.
  - My decision to revoke the authorization may result in my insurance company not being able to pay for my medical care and I may be liable for payment of the claim.
- Photocopies are provided by a contractual copy service that will invoice the requestor directly. Federal and state laws indicate that a reasonable, cost-based fee may be charged for copies of health care records.

Patient Signature: _____Date _____

or

Legal Representative: _____Date_____

(Signature/Authority/Relationship)

Witness :_____Date_____