West Virginia University Robert C. Byrd Health Sciences Center Eastern Division

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

Patient Name:		PHI / MR #
		Phone # :
		SSN:
I authorize:		
Name/Physician/Facility/Agency	Street Address/PO Box Number	City, State and Zip Phone/Fax
To release my Protected Heal	h Information (PHI) to:	
University Health	Associates, 171 Taylor Stre	et , Harpers Ferry, WV 25425
	(304)-535-6343 Fax: (304)-535-6618
The specific information to be rele	eased includes the following:	
History and Physical	Laboratory Studies	Special Instructions:
Staff/Progress Notes	Radiology Report	
Growth Records	Pathology Results	
Immunization Records	Other	_
Immunization Records Date(s) of Treatment	Reason for Request/Dis	sclosure:
Immunization Records Date(s) of Treatment HIV, Behavioral Health, and Sul released through this authorizatio DO NOT RELEASE:HIV I understand the following: My health record(s) will not be releas Only the records checked above will Although prohibited, it is possible tha liability as a result of the re-disclosur	Reason for Request/Dis bstance Abuse information contai n unless otherwise indicated below. Substance AbuseBehavion ed or obtained by UHA unless permission is be released for the above-stated reason(s). t my PHI may be re-disclosed by the facility e, and such information would no longer be p	sclosure: ned within the records indicated above will be ral Health/PsychiatricOther: granted by my signature on this authorization.
Immunization Records Date(s) of Treatment HIV, Behavioral Health, and Sul released through this authorization DO NOT RELEASE:HIV I understand the following: My health record(s) will not be release Only the records checked above will Although prohibited, it is possible tha liability as a result of the re-disclosur I am entitled to a copy of this completed. This authorization is valid for one yeast o Specific timeframe for valid	Reason for Request/Dis bstance Abuse information contai in unless otherwise indicated below. Substance AbuseBehavion ted or obtained by UHA unless permission is be released for the above-stated reason(s). t my PHI may be re-disclosed by the facility me e, and such information would no longer be p ted authorization form. ar from the date of signature, unless a specifi dity:	and within the records indicated above will be ral Health/PsychiatricOther: granted by my signature on this authorization. receiving my records, therefore, UHA has no responsibility or protected by the HIPAA Privacy Rule. In timeframe less than one year is documented:
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