Patients can now complete and submit release form electronically

Scan this QR code with the camera from your phone or tablet

| Patient Name: | Date of Birth: | Social Security No.(optional): |
|---|---|---|
| Provider's Name:<br>WVU Health System | Provider's Address:<br>PO Box 8049<br>Morgantown, WV 26506 | Provider's Phone:304-598-4110 Provider's Fax:304-598-4129 |

Recipient's Name:

Recipient's Address:

City State Zip

Recipient's Phone and Fax:

Phone No. Fax No.

This authorization will expire in 1 year (365 Days) unless otherwise specified:

**Description of information to be used or disclosed**

| | Date: | | Date: | | Date: |
|---|---|---|---|---|---|
| After Visit Summary | | EKG/ Rhythm Strips | | Office Visits | |
| Ambulance Run Sheet | | Emergency Room | | Operative/ Procedure | |
| Cancer Center | | History & Physical | | Pathology | |
| Cardiac Cath Report | | Immunizations | | Physical Therapy | |
| Consult | | Labs | | Radiology Report | |
| Discharge Summary | | Nurse's Notes | | Radiology Image | |

Other (please specify):

I acknowledge, and herby consent to such, that the released information may contain pregnancy, alcohol, drug abuse, psychiatric, HIV or AIDS information._____ (initials)

**I understand that:**

- **I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, information described above may be re-disclosed to other individuals or institutions and no longer protected by these regulations**
- **I understand that I may inspect and receive a copy of this authorization.**
- **I understand WVU Health System will not refuse to treat me simply because I do not sign this authorization.**
- **I understand that I may revoke this authorization at any time in writing except where action has already been taken in reliance upon this authorization.**

**Written revocation may be sent to PO Box 8049, Morgantown, WV 26506. By revoking this authorization:**
**Decision to revoke the authorization does not apply to any release of information that may have taken place prior to the revocation request.**
**Decision to revoke the authorization may result in your insurance company to not be able to pay for medical care and you may be liable to payment of claims.**

I have read the above and authorize the disclosure of the protected health information as stated. In accordance with state law, a minor patient's consent may be required for certain medical records:

Unless otherwise indicated below, a patient age 10 and older must sign for release of records in the event such records contain any information related to pregnancy, alcohol/drug abuse, psychiatric treatment, and HIV/AIDS or STDs.

For care rendered to a minor in Maryland only, (i) release of the following types of records require signature by the minor patient, unless the treating provider approves a release of such information to the minor's parent or guardian: drug abuse, alcoholism, venereal disease, HIV, pregnancy, contraception, examination or treatment of sexual assault, or mental or emotional disorders, and (ii) if the minor patient is married, emancipated, or has their own child, signature from the minor patient is required to release the minor patient's medical records of any type.

| Signature of Patient or Legal Representative: | Date: |
|---|---|
| Printed name of Patient of Legal Representative: | Relationship to Patient: |