Note:
<u>For Use Only With Outside Facility Records</u>

Release of Protected Health Information
<u>From other Facilities</u>

WVU Medicine
(ROI-013) (R 07/2021)

Patient's Name: ______________________________

Last First Middle

Date of Birth:___________Social Security#: _________________________________

Date:_________________Date of Service: __________________________________

I Authorize: ______________________________

Name/Physician Address City, State Phone# Fax#

To Release my Protected Health Information (PHI) to:

Attention:__________________
Dept. or Unit: _______________
Phone#_ _____________________________________
Fax# ________ ____________________________

The specific information to be released includes the following:

____History and Physical ____Cancer Center ____X-rays ____Advance Directives
____Discharge Summary ____Physical Therapy ____Labs
____Emergency Dept. ____Operative Reports ____Pathology
Other____
Special Instructions ____

*** HIV-BEHAVIORAL HEALTH-DRUG ALCOHOL-PREGNANCY INFORMATION contained within the records indicated above will be released through this authorization unless otherwise indicated below. (**Any records containing any of this info requires signature from age 10 and older to sign for release of records) ***********

Do not release:____HIV____Substance Abuse which includes (Alcohol-Drug Abuse)____Pregnancy Test ___Behavioral Health/Psychiatric_____Sexually Transmitted Disease_____other (please list)_______________

I understand the following:

- **My health record(s) will not be released or obtained unless my signature is on this authorization grants permission.**
- **Only the records checked above will be released for the above-stated reason.**
- **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 time frame less than one year is documented. Specific time frame for validity_____________.**
- **I understand I have the right to revoke this authorization prior to it being processed.**
- **Although prohibited, it is possible that my PHI may be re-disclosed by the facility receiving my records, therefore, WVUH has no responsibility or liability as a result of the re-disclosure, and the HIPAA Privacy Rule would no longer protect such information.**

____
SIGNATURE OF PATIENT (10 AND UP) DATE

____
SIGNATURE OF LEGAL REPRESENTATIVE RELATIONSHIP/ PROOF DATE

____
SIGNATURE OF WITNESS DATE