Patients can now complete and submit release form electronically

Patient Name:	Date of Birth:	Social Security No. (optional):
Provider's Name: WVU Health System (WVUHS)	Provider's Address: PO Box 8049 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 No. Email or Fax No.

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

Purpose of disclosure: ☐ At my request ☐ Healthcare / treatment ☐ Legal purposes ☐ Payment / insurance purposes ☐ Other purpose:

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 that the released information may contain pregnancy, alcohol, drug abuse, psychiatric, HIV or AIDS information and hereby consent to release of such information. ______ (initials)

I understand that:

- if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy laws, information described above may be re-disclosed to other individuals or institutions and no longer protected by these laws.
- I may inspect and receive a copy of this authorization.
- WVUHS will deliver my records electronically, which may include encrypted email, CD, or USB, or MyWVUChart, unless I provide specific or different instructions here: ____
- WVUHS will not refuse to treat me simply because I do not sign this authorization.
- 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 WVU Health System at PO Box 8049, Morgantown, WV 26506. My decision to revoke the authorization does not apply to any release of information that may have taken place prior to my revocation request. My decision to revoke the authorization may result in my insurance company not being able to pay for medical care and I may be liable for 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 aged 13 and older must sign for release of records in the event such records contain any information related to pregnancy, alcohol/drug abuse, psychiatric treatment, or HIV/AIDS or STDs.

For care rendered to a minor in Maryland only, (1) release of the above types of sensitive records (plus those relating to sexual assault) require signature by the minor patient, unless the treating provider approves release of such information to the minor's parent or guardian, and (2) 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: