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Patient Name:	**Date of Birth:**	**Social Security No.(optional):**
Provider's Name: WVU Health System	**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 and Fax:

Phone No. **Fax No.**

Expiration Date is 1 year (365 Days) from date signed, unless otherwise specified here:

Purpose of Disclosure:

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 hereby consent to such, that the released information may contain pregnancy, alcohol and drug use/abuse, psychiatric, HIV or AIDS information. **Initial here:** _____

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 will no longer be protected by these regulations.
- I may inspect and receive a copy of this authorization.
- WVU Health System will not refuse to treat me simply because I do not sign this authorization, but I understand that my insurance may not cover costs of treatment, and I may be liable for such costs, if I do not consent to release my information for payment purposes.
- Regarding revocation, I understand that:
    - I may revoke this authorization at any time in writing.
    - Revocation does not apply to release of information that took place prior to the revocation request. *See* NOPP-Full-Notice-6-17-2024.pdf
    - Written revocation may be sent to PO Box 8049 Morgantown, WV 26506.
    - Revocation may result in my insurance company not being able to pay for medical care, causing me to be responsible for payment of claims.

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If you are requesting records on behalf of a **minor (an individual under the age of 18)**, initials and signatures are needed as follows based on federal and state law:

1. **Initial:** For care rendered to a minor in West Virginia facilities: I certify to the best of my knowledge that the minor is not married; does not have a high school diploma or equivalent; is not emancipated; and that there is no court order preventing the release of records to me. If any of the above conditions apply, written consent of the minor is required for release of records, and the minor must sign below.

2. **Initial:** . For care rendered to a minor in Pennsylvania facilities: I certify to the best of my knowledge that the minor is not married; does not have a high school diploma or equivalent; is not emancipated; has not been pregnant. PHI released to a parent or guardian of a minor shall not contain information related to abuse/neglect, contraceptives, prenatal care (including pregnancy testing), drug and alcohol rehabilitation, or sexually transmitted diseases without informed, written consent of the minor. If any of the above apply, written consent of the minor is required for release of records, and the minor must sign below.

3. **Initial:** . For care rendered to a minor in Ohio facilities: I certify to the best of my knowledge that the minor is not emancipated. Medical records shall not be released to a parent or personal representative of a minor where the minor consented to the following treatment unless the minor consents to the disclosure of such medical information: Diagnosis and treatment of drug related conditions; Outpatient mental health services for minors age 14 and over; Emergency medical services for victims of sexual offenses; HIV testing; and Treatment and diagnosis of venereal diseases. If any of the above conditions apply, written consent of the minor is required for release of records, and the minor must sign below.

4. **Initial:** . For care rendered to a minor in Maryland facilities, I certify to the best of my knowledge that the minor is not married, emancipated, or has their own child. If any of the above conditions apply, written consent of the minor is required for release of records of any kind. In addition, release of the following types of records requires 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. If any of the above conditions apply and the treating provider does not approve release, written consent of the minor is required for release of records, and the minor must sign below.

5. For care rendered for substance use disorder by a Part 2 provider or program, as defined in 42 C.F.R. Part 2, a separate consent is required for those records.

Signature of Patient or Legal Representative:	Date:
Printed name of Patient of Legal Representative:	Relationship to Patient:
Signature of Minor if any above exceptions in 1-5 apply:	Date: