WVU Medicine

WVU HOSPITALS AND UNIVERSITY HEALTH ASSOCIATES
1 Medical Center Drive, Morgantown, WV 26506

**Authorization for Outside Release of Information Records Request**

FORM # (07/2025) 

**Note: For Use Only With Outside Facility Records**

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 _____

*** 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 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.**
- **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.**

## Authorization for Outside Release of Information Records Request



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