



Operated by WVU hospitals, Inc.  
Morgantown, WV 26506  
CNSTS 614 (R 11/2017)

Date: \_\_\_\_\_ MRN \_\_\_\_\_

**Authorization for Release of Information- Do not use for Chestnut Ridge Center or Behavioral Medicine Records**

1. Patient name \_\_\_\_\_  
(Last) (First) (Middle Initial)

Address \_\_\_\_\_  
(City) (State) (Zip)

Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ SSN \_\_\_\_\_ (to be used if unable to find patient with name or date of birth)

2. This information is to be used for the purpose of:

- Insurance  Workers Comp  Disability  Attorney  Military
- Physician or other Health Care Provider-- (required to complete 3 A)  Self

3. This information is to be: (only select ONE option)

- Mailed to Patient  Hand Carried by \_\_\_\_\_  Will Pick up Date \_\_\_\_\_ Time \_\_\_\_\_
- Email: service@hoosierservicesinc.com (Photo ID Required) (Allow 24 hours for Continue care. 7-21 days for other)
- Release to MyWVUChart  Mail to Physician or Health Care Provider (all information is to be completed)

3A. Hoosier Services Inc.

18032 \_\_\_\_\_ Yorba Linda CA 92886  
 (Name of Facility) Lemon Dr., #C-618  
 (Complete Mailing Address) (City) (State) (Zip)  
 800.882.4156 800.882.4957 Email: service@hoosierservicesinc.com  
 (Phone Number required) (Fax number required)

4. Release the following with photo static copies regarding my treatment: Require items must be checked: Medical Records provided on a CD (viewed by computer): **(please only mark the options that you know received treatment for while a patient.)**

- \_\_\_\_\_ Office Visits \_\_\_\_\_ Cancer Center \_\_\_\_\_ X-Ray Reports (Reports only) \_\_\_\_\_ CD (Disc of Images)
- \_\_\_\_\_ Physical Therapy \_\_\_\_\_ Operative Report \_\_\_\_\_ Pathology Reports \_\_\_\_\_ History and Physical
- \_\_\_\_\_ Emergency Dept. \_\_\_\_\_ Laboratory Results \_\_\_\_\_ Immunization Record \_\_\_\_\_ Discharge Summary
- \_\_\_\_\_ HVI (Heart & Vascular Institute)

Other (specific instructions) \_\_\_\_\_

Covering record time period from \_\_\_\_\_ to \_\_\_\_\_ and hereby release WVUH from all legal liability that may arise from further disclosure of said records.  
(Required – Do not Date Ahead)

\*\*\*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) \_\_\_\_\_

**PLEASE READ:** As of July 6, 2017, person(s) and companies requesting copies of healthcare records and radiology images for personal use will be charged according to West Virginia code §16-29-2 (2017). Requests will be pre-billed and payment received before records and images are released. West Virginia Code states that a health care provider may charge a \$20 search fee along with 40 cents per page for paper records or 20 cents per page for electronic documentation plus the costs of postage for copies of healthcare records. Our standard of delivery is CD electronic format for all medical records requests. The search fee will be waived for patients requesting records. Please allow up to 30 days for processing. Copies of your records mailed to your physician will be provided at no charge.

\_\_\_\_\_  
Signature of Patient (Age 10 and Up required)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
DATE

- My health record(s) will not be released or obtained unless permission is granted by my signature on this authorization.
- Only the record(s) checked above (front page) will be released for the above will be released for the above stated reason (reasons).
- Although prohibited, if as 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 such information would no longer be protected by the HIPAA privacy rules.
- 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:
  - Specified time from for validity: \_\_\_\_\_
- I have the right to revoke this authorization at any time by sending a written request to:
- West Virginia University Healthcare, PO Box 8049 Morgantown, WV 26506  
Attention: Director of Health Information
- By revoking this authorization:
  - My decision to revoke the authorization does not apply to any release of PHI that may have taken place prior to the revocation request.
  - My decision to revoke the authorization may result in my insurance company not being able to pay for the medical care and I may be liable for payment of the claims.
  - WVUH cannot require me to sign the authorization in order to receive treatment
- This authorization may be revoked at any time by the patient. The revoking of this authorization shall not cancel any prior action that has transpired. This authorization shall remain valid for the production of specified records until the following date \_\_\_\_\_ or a period of 1 year from the date of form completion.  
A new authorization will be required for any new visits to WVUH that occur after the date of this authorization. Authorizations cannot be given for future visits.
- NOTE: ADDITIONAL INFORMATION REGARDING HAND-CARRIED RECORDS OR MEDICAL INFORMATION INCLUDING AIDS, SEXUALLY TRANSMITTED DISEASE, HIV RELATED DISEASES, DNA SCREENING, BLOOD ALCOHOL CONTENT, ALCOHOL/SUBSTANCE ABUSE, ADOPTION AND / OR PSYCHIATRIC RECORDS ARE REQUESTED ON THE REVERSE SIDE OF THIS SHEET.

**Health Information Management Department**

Requests can also be sent via email rather than faxing or mailing the release. Please send requests to

[WVUHROIREQUEST@WVUMEDICINE.ORG](mailto:WVUHROIREQUEST@WVUMEDICINE.ORG)

JW Ruby Memorial Hospital / WVU Medicine  
PO Box 8049 Morgantown, WV 26506-8049 PHONE: 304-598-4110 FAX: 304-598-4129

AUTHORIZATION FOR PERSONAL REVIEW OF MEDICAL RECORD

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