

WVVA HEALTH CARE ALLIANCE, P.C.

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

SOCIAL SECURITY NUMBER: _____

I Hereby Authorize: _____

PHYSICIAN FROM WHOM YOU ARE REQUESTING RECORDS

PROVIDE CONFIDENTIAL INFORMATION CONTAINED WITHIN MY MEDICAL RECORD TO:

Information to be released should include Other: _____

Please check the type of information to be released:

<input type="radio"/> Complete health record	<input type="radio"/> Office Notes	<input type="radio"/> Discharge summary
<input type="radio"/> History and physical exam	<input type="radio"/> Consultation reports	<input type="radio"/> Progress notes
<input type="radio"/> Laboratory test results	<input type="radio"/> X-ray reports	<input type="radio"/> X-ray films / images
<input type="radio"/> Immunization record	<input type="radio"/> Demographic/insurance information	<input type="radio"/> Itemized bill

<u>Purpose of Request:</u>		
Treatment or Consultation <input type="radio"/>	At the request of the patient <input type="radio"/>	Billing or Claims Payment <input type="radio"/>

Information to Be Released – Covering the periods of Health Care:

* All Dates of Service _____

* From (date) _____ to (date) _____

I, the undersigned, have read and authorized the staff of the disclosing facility named to disclose information as herein contained. I understand the information disclosed by this authorization may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1998. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I does not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. Except to the extent that action has been taken in compliance with this request, this authorization may be revoked by me at any time, by submitting a notice in writing to the facility’s Privacy Officer at _____ . Unless revoked, this authorization will expire on the following date or event: _____ ; unless otherwise specified.

_____ Signature of Patient/Legal Guardian	_____ Date
Initial _____ I acknowledge and hereby consent to such, that the release information may contain alcohol abuse, psychiatric, Sexually transmitted disease, Hepatitis B or C, HIV testing, HIV results or AIDS information.	