Vandalia Health
Webster Memorial Hospital

AUTHORIZATION OF USE AND DISCLOSURE OF HEALTH INFORMATION

**** Incomplete forms will be returned to requester****

Day Phone____

PATIENT NAME: ____ **DATE OF BIRTH**: __________________ **LAST 4 SSN:** _________

PATIENT ADDRESS: Street: ____ City: ____________________ State: ______________ Zip: ____________

Date (s) of Service Requested: ___________________________________ **OTHER NAMES:** ___________________________

Who do you authorize to disclose your information:

☐ Webster Memorial Hospital ☐ Other____

What to release:

☐ Office Visit Notes
☐ ED Record
☐ Laboratory Results
☐ DC Summary
☐ Pathology Reports
☐ Immunization Records
☐ Oncology Records
☐ Cardiology Records
☐ Radiology
☐ Operative
☐ Consult Reports
☐ HP
☐ Radiology Image
☐ Billing Records
☐ Entire Record
☐ **Other**(be specific) : ___________________________

Who do you want us to send the information to: **(must be specific):** ____

How do you want it sent (Choose one):

1. ☐ **Mailed to:** Street: ____ **CITY:** ____________________ **STATE:** _____ **ZIP:** __________
2. ☐ **Fax (Number REQUIRED):**___________________________ **Phone Number (REQUIRED)**___________________________

   Electronic method may be used for large files
3. ☐ **Delivered to patient email address:** ___________________________________

   *Webster Memorial Hospital will transfer information to the email address of your choosing. However, WMH is not responsible for any potential risks and/or risks and/or consequences if you choose to use an unsecure email address.
4. ☐ Review the chart in person without getting a copy-by appointment only
5. ☐ ***I will pick this up in person***

Why/Purpose of Disclosure:

☐ To the patient - therefore, this is N/A ☐ Continuity of Care ☐ Insurance ☐ Litigation
☐ Disability Determination ☐ Personal ☐ Worker's Compensation ☐ Other (Please specify): ____________________

Authorization to Release Information:

1. I understand that, by signing this Authorization to Disclose Health Information, I am giving my permission to Webster Memorial Hospital, and/or its subsidiaries("WMH"), to disclose all the records I have specified for release to the designated recipient. Unless indicated below, I specifically authorize the release to include such confidential health care information as may be contained in the records I have designated for release and which may relate to behavioral or mental health services, treatment for alcohol and drug abuse, sexually transmitted infection, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

****Check below any such categories of records that you are NOT authorizing DHS to release:**

☐ Behavioral/ Mental Health ☐ Sexually Transmitted Infections ☐ HIV ☐ Alcohol/Drug Abuse ☐ AIDS

NOTE: ** Psychotherapy Notes A separate authorization is required, although DHS is not legally obligated to provide a patient with access to Psychotherapy Notes.**

Other Special Instructions, if any: ____

2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment, payment, enrollment in a health plan, or eligibility for benefits unless I have agreed to receive the treatment as part of a research project or in order to provide my information to a third party. Under those circumstances, I understand that my refusal to sign may result in WMH's refusal to treat. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM Department at the facility.

3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation at the address listed on page two. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 180 days from the date of signature. If applicable, insert another date or event of expiration: ____________________

4. I understand that I will be given a copy of this authorization form upon request. Furthermore, I understand that charges for record production, regardless of media used, will be applied according to State/Federal Law, and prepayment may be required. Records mailed directly to a provider will not be subject to a a charge.

All requests are processed within 30 DAYS of receipt as permitted by State/Federal Law.

Signature of Patient or Legal Representative ___________________________________ **Date:** __________________

If the patient is 12 - 17 years old, you must attest to specific exceptions on the following page **BEFORE** this request will be processed.

Attestation Needed Prior to Releasing Records for Patients 12 - 17 Years Old

I **attest** that **none** of the following apply to the child for which I am requesting records:

(1) The minor child has graduated high school or equivalent;

(2) The minor child is emancipated; or

(3) The minor child is married.

Relationship to the patient:

- ☐ Parent
- ☐ Foster Parent
- ☐ Legal Guardian
- ☐ Kinship Placement

Documentation of relationship to patient may be required to support this request.

Requestor's Signature: ____

Date / Time: ____

Our contact information:

Davis Medical Center **Phone:** 304-637-3381 **Fax**: 304-637-3482
Attn: Health Information
P.O. Box 1484 Elkins WV 26241

Broaddus Hospital **Phone:** 304-457-8520 **Fax:** 304-457-2809
Attn: Health Information
1 Healthcare Drive, Philippi WV 26416

Webster Memorial Hospital **Phone:** 304-847-5682 **Fax:** 681-691-0068
Attn: Health Information
125 Diana Drive Webster Springs, WV 28188