WHEN READY: ☐ MAIL ☐ CALL ☐ FAX

ROI Identification Verification

________ Photo ID

________ Other: ______________________

________ Initial

WHEELING HOSPITAL

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

RETURN TO: Medical Records Department
Wheeling Hospital
1 Medical Park
Wheeling, WV 26003

FAX NUMBER: 304-243-5074

PATIENT'S NAME: ______________________ **BIRTHDATE:** ______________

PATIENT'S ADDRESS: ______________________________
(Street)

______________________________ **TELEPHONE #:** ______________
(City) (State) (Zip Code)

MAIDEN/OTHER NAMES: ______________________________

I authorize: ☐ Wheeling Hospital / ☐ ______________________________

to release all information contained in my medical records, including alcohol and drug abuse records (if any); mental health and/or psychological service record (if any); information about serious communicable diseases and infections which include human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and AIDS-related complex (ARC); and social services records (if any) to individual(s) or organization(s) listed below under the conditions specified below:

1.) Name of person(s) or organization(s) to whom disclosure is to be made: ☐ Wheeling Hospital Medical Park
Wheeling, WV 26003

OR: ______________________________
(Name) (Street) (City) (State) (Zip Code)

2.) Specific date(s) of hospitalization/treatment and specific type of information to be disclosed:

____

____

3.) Purpose and need for such disclosure:

☐ Medical ☐ Personal ☐ Legal ☐ Insurance ☐ At the request of the individual

Is this request for purposes for supporting a Social Security claim or appeal? ☐ No ☐ Yes

If YES, is the requestor financially unable to pay full copying charges by reason of: ☐ unemployment

☐ disability ☐ income below the federal poverty level ☐ receipt of state federal income assistance

4.) Consent will expire on: ______________________________
(One year from date of signature if not specified.)

5.) I understand that I may revoke this authorization in writing at any time except to the extent that Wheeling Hospital has already relied on this authorization.

6.) I understand that protected health information, once disclosed to others, may be re-disclosed to individuals or organizations not subject to HIPAA privacy standards and may no longer be protected by HIPAA.

7.) I understand that Wheeling Hospital may not condition treatment on my completion of this authorization form.

X ______________________________ **Date:** ______________

Signature of Patient or Parent (if patient is a minor) or
Personal Representative, Legal Guardian or Closest Relative, if patient unable to sign:

Reason: ______________________________ Relationship: ______________

Witness: ______________________________ Date: ______________