WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
HIPAA AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION

Patient Name (Please print): _____ Date of Birth: _____

Telephone Number: _____ ID Number: _____ Claim Number: _____

_____
Address City State Zip County of Residence

Description of Information You Wish to be Disclosed
(Place your initials beside the documents you wish to be released):

Dates of Documentation to be Released: _____

☐ Medical / Prescription Claims Information
☐ Case Status / Eligibility Information
☐ Protected Health Insurance for a Minor
☐ Other: _____

Who Do You Authorize to Disclose this Information?

☐ Government Agency or Department
☐ All health care sources including: hospitals, clinics, labs, nursing homes, physicians, registered professional nurses, physician's assistants and psychologists
☐ All health plans
☐ Employers
☐ Educational Sources
☐ Others who may know about my situation (family, neighbors, friends, public officials)
☐ Other: _____

Who Is Authorized to Receive your Information?

☐ Elected Representative: _____
☐ Other: _____

Reason You Would Like Your Information Disclosed:

☐ To investigate my inquiry Other: _____

Expiration Date: This authorization is good for:

☐ 6 months from the date signed (beside my signature)
☐ Other – Must be less than 5 months: _____

Signature: _____ Date: _____

If this authorization is signed by someone who is not the patient listed at the top of this form, provide a description and legal documentation of the signer's authority to act for the patient. A copy of the required legal documents MUST be attached to the authorization.

See page 2 of this form for the "Notice to Patient."

Routing Instructions: Send the original and any attachments to the entities or sources authorized to disclose the information. Provide the patient with one copy of this form. Keep a copy of the form and any attachments for your files for six (6) years.

Notice to Patient

You may revoke this authorization at any time. To revoke this authorization: (1) you must send a written statement to your entities or sources that you no longer wish to disclose information about you; and (2) send a copy of your written revocation statement to:

WV DHHR Office, _____

_____

The statement must identify this authorization by referring to the date it was signed. The statement must include the date on which this authorization is no longer in force.

If you revoke this authorization, the entities or sources may still use and disclose the information for the purposes listed on this form, if the entities or sources have already taken action in reliance on this authorization. Also, if this authorization is to permit the entities or sources to disclose information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest a claim or to contest your coverage.

You may refuse to sign this authorization. If you refuse to sign this authorization, DHHR may not be able to assist you in addressing your concern.

The following *italicized* language is required by federal law, but does not necessarily apply to your request for assistance from us. DHHR is neither a health care provider, health plan nor a health care clearinghouse.

You do not need to sign this authorization to receive health care services EXCEPT in the following circumstances:

- *If the only purpose for providing you with a health care service is to obtain information to disclose to someone else, then you must authorize that disclosure in order to receive the service. (Example: physical examinations required to obtain certain types of licenses.)*

- *If the health care services are related to research, you may be required to authorize the use or disclosure of your health information for the research. This applies only to health information related to the research services. The use and disclosure of your information will be limited to what is necessary for the research. If you do not authorize the use and disclosure of your information for the research, you may not be eligible to receive the services.*

You do not have to sign this authorization to receive payment, to enroll in a health plan, or to be eligible for benefits, EXCEPT:

- *If this authorization is sought for the purpose of determining your eligibility for benefits or enrollment, then you must authorize us to obtain the necessary information or the benefits or enrollment may be denied.*

- *If this authorization is sought for the purpose of underwriting or risk rating determinations, then you must authorize us to obtain the necessary information or benefits or enrollment may be denied.*

- *Under federal law, you do not have to authorize us to receive the private notes from counseling sessions that are kept by a mental health professional, as a condition of payment, enrollment in a health plan, or eligibility for benefits.*

A person or organization that receives your information because of this authorization may have the legal right to disclose this information to other people or organizations without your knowledge or consent. However, in some situations, State law may prevent the person or organization that receives your information from further disclosing it without your consent.