WVU Physicians of Charleston

Health Information Management
3110 MacCorkle Avenue, SE
Charleston, WV 25304
Phone: (304) 341-1550
Fax: (304-341-1549

AUTHORIZATION TO DISCLOSE PSYCHOTHERAPY NOTES

PATIENT NAME: _____ **DATE OF BIRTH**: _____
[Please print full name]
Last 4 SSN: _____ **DAY PHONE**: _____ **OTHER NAMES USED:** _____

Psychotherapy Note Information Requested: (Complete options below)

Date(s) of Service Requested: _____

METHOD OF RELEASE: ****Complete mailing address is required. ** Incomplete forms will be returned to requester.**

Person/Facility to Receive Information: _____

☐ **Mailed to:** ***STREET:*** _____ ***CITY:*** _____ ***STATE:*** ____ ***ZIP:*** _____

☐ **Fax Number:** _____

☐ **Email Address (Patient requests only):** _____
**West Virginia University Medicine is not responsible for the potential risks associated with unsecured email transmission of your protected health information.

Purpose of Disclosure:

☐ Continuity of Care ☐ Insurance ☐ Litigation ☐ Worker's Compensation
☐ Disability Determination ☐ Personal ☐ Other (Please specify): _____

Authorization to Release Information:

1. I understand that, by signing this Authorization to Disclose Health Information, I am giving my permission for WVU Physicians of Charleston to disclose psychotherapy notes as defined in the Health Insurance Portability and Accountability Act (HIPAA) for all dates of service as specified above.

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. I understand that any disclosure of information carries with it the potential for an 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 304-341-1550

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 to: Director of Health Information Management, WVUPC, 3110 MacCorkle Avenue, SE, Charleston, West Virginia 25304. 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 copying charges will be applied according to State/Federal Law. This current rate is $25.00 per hour cost based fee, pre-payment MAY BE required. All requests are processed within 30 DAYS of receipt as permitted by State/Federal Law**.

Signature of Patient or Legal Representative_____
DATE

If signed by legal representative, relationship to patient: _____

For Provider Use Only

☐ Approve

☐ Deny

Provider Signature _____ Date _____

Provider Notes _____

_____

_____

_____