West Virginia School of Osteopathic Medicine Clinic, Inc.

ROBERT C. BYRD CLINIC

1464 Jefferson St. N., Lewisburg, West Virginia 24901 ▪ Telephone (304) 645-3220 ▪ Facsimile (844) 479-4545

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION (PHI)

Patient Identification:

Printed Name: ________________________________ Date of Birth: _____________Social Security #: _________________________________

Address: ____ Telephone:___________________________________

☐ I authorize RCBC to **release** my Protected Health Information (PHI) to:

Name:____

Address:____

Phone #__________________________ Fax #__________________

☐ I authorize RCBC to **obtain** my Protected Health Information (PHI) from:

Name:____

Address:____

Phone #_________________________ Fax #________________________

Note: If PHI is obtained by RCBC and patient subsequently is not accepted into RCBC, then all PHI received by RCBC will be returned to originating practice.

Information To Be Released/Obtained - Covering the Periods of Health Care

Dates of Treatment From (date) ______________________________ To (date) ________________________

Reason for Request: ____

Please check type of information requested:

☐ Entire Medical Record ***(note: if you are requesting your medical record to be transferred from another medical provider to RCBC you must ask that your entire medical record be provided)***	☐ Abstract of last two years – includes last 2 years of clinical notes, labs, x-rays and EKG's for past 3-6 months, shot records, growth chart , pathology and radiology for past 1 year	☐ Progress Notes
☐ Consultation Reports	☐ Laboratory Test Results	☐ X-Ray Reports
☐ History & Physical Exam	☐ Pathology Report	☐ X-Ray Films/Images
☐ Immunization Record	☐ Itemized Bill	☐ Behavior Health

☐ Other (Specify)____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Check One: ☐Yes ☐No ___________________ Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Check One: ☐Yes ☐No ___________________ Initials

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Robert C. Byrd Clinic, 1464 Jefferson St. N, Lewisburg, WV 24901. Unless revoked, this authorization will expire six (6) months from date signed below or on the following date specified ______________________________.

Re-disclosure

I understand that information disclosed/obtained by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. 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.

Signature of Patient, Guardian, or Personal Representative Who May Request Disclosure

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization form unless specified above under Reason of Request. I can inspect or copy the protected health information to be used or disclosed.

Patient/Guardian/Representative Signature: ____Date: ___________________________

Legal Capacity of Representative: ____

Identity of Requestor Verified By ☐ Photo ID☐ Matching Signature ☐ Other, specify: ____

Completed/Verified by: ____ **Date**: ___________________________

This Section MUST Be Completed By a RCBC Associate for This Release To Be Valid **Rev. 8/2017**