

**CONSENT FOR RELEASE OF MEDICAL RECORDS USE &
DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Patient Name: _____ Social Security #: _____ Date of Birth: _____ Patient Phone Number: _____

Current Street Address: _____ City: _____ State: _____ Zip Code: _____

I hereby authorize Pineview Gynecology to use or disclose the specific health information described below only for the purpose and parties as described.

I AM REQUESTING PINEVIEW GYNECOLOGY RELEASE MY MEDICAL RECORDS TO: (Please Choose One)

PHYSICIAN (DIRECTLY TO PHYSICIAN- NO FEE)

Physician Name _____
Practice Name _____
Address _____
City, State, Zip _____
Phone _____
Fax _____

PATIENT (FEES APPLY)

Patient Name _____
Address _____
City, State, Zip _____
Phone _____
Fax _____

3RD PARTY (FEES APPLY)

Insurance Company/SSA/DHHR _____
Company Name _____
Address _____
City, State, Zip _____
Phone _____
Fax _____

FORMAT OF RECORDS RELEASE – Please Note: Pineview Gynecology will forward **two (2) years** of medical records unless otherwise indicated. Records released to the patient or a third party by disk/paper copy will be subject to medical record fees in accordance with the WV State Law. Records faxed directly to a physician's office will be sent free of charge. Records going to the patient or 3rd party will need to pay the medical record fee (plus tax) prior to the release of records.

(Please Choose Method of Delivery):

- | | | | |
|---|--------------------|-------------------------------|--|
| <input type="checkbox"/> Fax | | <input type="checkbox"/> Mail | <input type="checkbox"/> Patient Pick-up |
| <input type="checkbox"/> Records on Disk by | Please choose one: | <input type="checkbox"/> Mail | <input type="checkbox"/> Patient Pick-up |
| <input type="checkbox"/> Paper Copy by | Please choose one: | <input type="checkbox"/> Mail | <input type="checkbox"/> Patient Pick-up |

DESCRIPTION OF SPECIFIC INFORMATION TO BE USED OR DISCLOSED:

Please note: Only records or orders/results from Pineview Gynecology Providers will be released.

- | | | | |
|--|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Office Notes (may contain reference to Super-Confidential PHI as listed below)) | <input type="checkbox"/> Pap Smears | <input type="checkbox"/> X-rays | <input type="checkbox"/> Labs |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Pathology | <input type="checkbox"/> Mammograms | <input type="checkbox"/> Ultrasounds |
| <input type="checkbox"/> Hospital Summary | <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Other: _____ | |

SUPER-CONFIDENTIAL PROTECTED HEALTH INFORMATION:

Please note: The following information will only be released if checked with a signature. Otherwise, this information will be excluded from medical records release.

- | | | |
|--|-----------------------------|-------------|
| <input type="checkbox"/> HIV Records/Test Results/AIDS | Signature to release: _____ | Date: _____ |
| <input type="checkbox"/> Sexually Transmitted Diseases Records | Signature to release: _____ | Date: _____ |
| <input type="checkbox"/> Psychotherapy Records | Signature to release: _____ | Date: _____ |
| <input type="checkbox"/> Alcohol and Substance Abuse Diagnosis/Records | Signature to release: _____ | Date: _____ |
| <input type="checkbox"/> BRAC/Genetic Test Records | Signature to release: _____ | Date: _____ |

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THIS INFORMATION IS BEING REQUESTED FOR THE FOLLOWING PURPOSE(S):

- Continued Care & Treatment Changing Providers Moving to New Area Insurance Personal Use Legal Reason
 Worker's Compensation Disability At the Request of the Patient Second Opinion Other: _____

This authorization shall remain in effect from the date signed below until **1 YEAR** (Expiration date or event).

I understand Pineview Gynecology is complying with state and federal laws by warning recipient(s) records are prohibited from re-disclosure. **Initial:** _____

I understand that Pineview Gynecology will receive compensation from a third party for the use or disclosure of my information. **Initial:** _____

I acknowledge that Pineview Gynecology, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed the NOPP of Pineview Gynecology and have been given the opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated authorization shall be as effective as the original. I release, hold harmless, and agree to indemnify Pineview Gynecology, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize Pineview Gynecology to use and disclose verbally, by mail, fax, encrypted or unencrypted email, the **super-confidential information** (Psychotherapy, HIV, AIDS, Sexually Transmitted Diseases, BRAC, and Alcohol and Substance abuse records) as I indicated on page 1 of this form by checking the box and confirmed by my signature.

I may inspect a copy of my protected health information to be used or disclosed under this consent. I have the right to revoke this authorization in writing by contacting Pineview Gynecology, attention Privacy Officer. Pineview Gynecology has not conditioned provision of services to or treatment of my upon receipt of this signed authorization; and that I may refuse to sign this authorization.

Patient Name (print name): _____ Patient Signature: _____ Date: _____

Patient Representative's Name: (printed) _____ Patient Representative's Signature: _____

Date: _____ Relationship to Patient/Describe Authority: _____

WV State Law HB4560 Medical Records – “reasonable fees” can be charged for both paper and electronic copies of medical records. These cost-based fees include the costs of copying, supplies and labor for copying, and postage (if mailed).

In order for medical records to be processed, the fees which apply, must be paid in full prior to the release of records. Thank you.