West Virginia Authorization to Use and/or Disclose Protected Health Information

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Recipient Information:

Last Name: _____ *First Name*: _____ *Middle*: _____

Date of Birth: _____ *Home Phone*: _____ *Medicaid ID*: _____

Street Address: _____

City: _____ *State*: _____ *Zip Code*: _____

A. What medical information are you giving permission to be used? _____

_____

_____

B. Who are you giving permission to **use** your medical information? _____

_____

_____

C. Who is to **receive** your medical information? _____

_____

_____

D. Why are you giving permission to have your medical information used?_____

_____

_____

_____

E. When do you want the permission to have your medical information used to stop? _____

_____

_____

F. I hereby **authorize** the use and/or disclosure of the PHI described in Sections A-E above effective _____ *(MM/DD/YYYY).*

_____ _____ _____

Signature (must be in ink other than black) **Title** (if Legal Representative*****) **Date**

West Virginia Revocation to Use and/or Disclose Protected Health Information

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I hereby revoke the authorization for use and/or disclosure of the PHI described in sections A_E above effective _____ (MM/DD/YYYY).

_____ _____ _____

Signature (must be in ink other than black) **Title** (if Legal Representative*****) **Date**

***If submitting this request on behalf of a person whom you are the legal representative, the State of West Virginia, Bureau for Medical Services will require proof of your legal status prior to the release of this information.**

Recipient Use Only: Staff Member: **Date Sent:**

_____ _____