Dear Patient:

Thank you for contacting **Community Care of West Virginia** Medical Records Department. To better serve you with your request for medical records, **Community Care of West Virginia** has partnered with Sharecare Health Data Services.

Sharecare Health Data Services will fulfill your request for records in a safe, secure, and timely manner.

To receive a copy of your records, you will need to complete and return the attached Authorization form. Please make sure you have *specific* instructions included as to **what** records you are requesting and **where** you are requesting they be sent. You also have a choice of **how** you would like to have your records delivered. For records to be delivered directly to you, please choose mail. For records to be delivered to another doctor, please choose fax or mail. Please select only one option. *The fax delivery option may only be used for records going to a doctor.* ***Please mail/fax/drop-off the completed Authorization form to*** **Community Care of West Virginia.**

If you choose to fax your request, please fax to: 304-472-1341. Please include a copy of your Driver's License.

If you choose to mail request, please send to:
Community Care of West Virginia
Attention: Medical Records
37 W. Main Street
Buckhannon, WV 26201-2235

For Records being sent to Another Health Care Provider
Please provide as much contact information for your other Doctor, including the address, phone & fax.

You can contact a Sharecare Health Data Services representative at any time by calling:

1-866-967-0133.

Thank you,

Medical Records Supervisor
Community Care of West Virginia

Date: _____

Authorization for Use, Release and/or Disclosure of Protected Health Information

1. Patient Name: _____
(Last) (First) (Middle Initial)

Address: _____

Phone: _____ Birthdate: _____ SSN: _____

2. This information is to be used for the purpose of (Check all that apply):
□ Self □ Insurance □ Workers' Comp □ Disability □ Attorney (required to complete 3A)
□ Physician or other Healthcare Provider (required to complete 3B) □ Military
□ Requesting for marketing purposes □ Other (Specify): _____

3. This information is to be provided via □ digital CD □ on paper/hard copy:
□ Mailed to Patient □ Hand Carried by _____ (Photo ID Required)
□ Will Pick Up on Date: _____ (Allow At Least 5 Business Days)

3A. □ Mail to Attorney (all information is to be completed):

_____
(Name of Attorney or Firm)

_____
(Complete Mailing Address) (City) (State) (Zip)

_____
(Phone Number Required) (Fax Number Required)

3B. □ Mail to Physician or Healthcare Provider (all information is to be completed):

_____
(Name of Physician, Provider or Facility)

_____
(Complete Mailing Address) (City) (State) (Zip)

_____
(Phone Number Required) (Fax Number Required)

4. Release the following healthcare information (INITIAL all that apply):

_____ All healthcare information in my record

_____ Healthcare information in my medical record relating to the following treatment or condition:
_____

_____ Healthcare information in my medical record for dates: _____

_____ Other (e.g., X-rays, bills, labs) Provide specific instructions and dates: _____

_____

*** **NOTE:** **INFORMATION REGARDING HIV STATUS, BEHAVIORAL HEALTH OR PSYCHIATRIC TREATMENT, SUBSTANCE ABUSE (INCLUDING DRUG AND/OR ALCOHOL) DISORDER DIAGNOSIS/TREATMENT, PREGNANCY STATUS, AND SEXUALLY TRANSMITTED DISEASE** contained within the records indicated above will be released through this authorization unless otherwise indicated below.

DO NOT RELEASE RECORDS PERTAINING TO (INITIAL all that apply)**:**

_____ HIV _____ Substance Abuse (which includes Alcohol and/or Drug Abuse)

_____ Pregnancy Test _____ Behavioral Health/Psychiatric _____Sexually Transmitted Disease

_____ Other (Specify): _____

5. I authorize the release of the protected health information identified above (INITIAL all that apply):

_____ Created on or before the date of this request only.

_____ Created on or before the date of this request and created after the date of this request for healthcare services I received through the period up to and including the expiration date listed below.

6. Form of protected information to be released:

_____ Written

_____ Verbal

7. This Authorization Ends: (**NOTE:** This document does not permit disclosure of protected health information for a period of more than six months after the date it is signed.)

_____ Days from the date signed: _____ (number of days) from (date): _____

_____ When the following event occurs: _____
(Not longer than six months from the date signed)

(**NOTE:** If no date or event is stated, expiration shall be six months from the date signed. The requested information cannot be provided after the expiration of this authorization without execution and delivery of a new authorization.)

8. **MY RIGHTS:**
   - I understand that I do not have to sign this Authorization in order to get healthcare (treatment, payment, or enrollment) and that I may refuse to sign this Authorization. However, I may have to sign an Authorization form in order to take part in a research study; or to receive healthcare for the express purpose of creating healthcare information for a third party (i.e., life insurance physical, etc.)
   - I understand that I have the right to inspect or have copies of the protected health information to be used or disclosed by the above listed entity pursuant to this Authorization.
   - I understand that I am entitled to a copy of this completed Authorization.
   - I understand that my healthcare record(s) will not be released or obtained unless permission is granted by my signature on this Authorization.
   - I understand that only the record(s) checked above will be released for the above stated purpose(s).

- Although prohibited, it is possible that my protected health information may be re-disclosed by the recipient of my records under this Authorization; therefore, Community Care of West Virginia has no responsibility or liability as a result of any re-disclosure, and such information would no longer be protected by the HIPAA privacy rules.

- I understand that this Authorization is valid for six (6) months from the date of signature, unless a specific timeframe less than six months is documented above.

- I understand that I have the right to revoke this Authorization at any time by sending a written request to Community Care of West Virginia, 37 West Main Street, Buckhannon, WV 26201; however, I understand that my revocation shall not be effective as to the use and/or disclosure of protected health information that I have previously authorized or where other action has been taken in reliance on an Authorization I have previously signed.

NOTE: Persons and companies requesting copies of healthcare records for personal use will be charged according to West Virginia Code § 16-29-2. Requests for records will be pre-billed and payment received before records will be released. The West Virginia Code states that a healthcare provider may charge reasonable labor costs plus the costs of postage for copies of healthcare records. Copies of your records mailed to your physician will be provided at no charge.

I fully understand and accept the terms of this Authorization.

_____ _____
Signature of Patient or Representative Date

_____
Printed Full Name of Patient or Representative (if applicable)

_____
Authority or Relationship of Representative (if applicable)

_____ _____
Community Care of West Virginia Representative Date

Requested by the following Community Care location:

___ Behavioral Health: 65 Professional Place, Suite 101, Bridgeport, WV 26330/Phone: 304-848-5770/Fax: 304-842-5477
___ Bridgeport (Primary Care): 65 Professional Place, Suite 101, Bridgeport, WV 26330/Phone: 304-848-5770/Fax: 304-842-5477
___ Big Otter: 797 Clinic Road, Ivydale, WV 25113/Phone: 304-286-4200/Fax: 304-286-2107
___ Buckhannon (CareXpress): 4 Northridge Drive, Suite 118, Buckhannon, WV 26201/Phone: 304-473-1440/Fax: 304-473-1441
___ Buckhannon: 37 West Main Street, Buckhannon, WV 26201/Phone: 304-473-5600/Fax: 304-472-1341
___ Clarksburg: 700 Oakmound Rd, Clarksburg, WV 26301/Phone: 304-623-6330/Fax: 304-623-6220
___ Clay: 122 Center Street, Clay, WV 25043/Phone: 304-587-7301/Fax: 304-587-2464
___ Flatwoods: 266 Skidmore Lane, Sutton, WV 26601/Phone: 304-765-4400/Fax: 304-765-0354
___ Flatwoods (CareXpress): 273 Skidmore Lane, Sutton, WV 26601/Phone: 304-765-0351/Fax: 304-765-7019
___ Green Bank: 4498 Potomac Highlands Trail-PO Box 85, Green Bank, WV 24944/Phone: 304-456-5115/Fax: 304-456-5118
___ Little Meadow: PO Box 27-100 Pickens Road, Helvetia, WV 26224/Phone: 304-924-5453/Fax: 304-924-5496
___ Marlinton: 821 3rd Avenue, Marlinton, WV 24954/Phone: 304-799-4404/Fax: 304-799-4425
___ Rock Cave: PO Box 217-78 Queens Alley Road, Rock Cave, WV 26234/Phone: 304-924-6262/Fax: 304-924-6699
___ West Milford: 597 Liberty Street, West Milford, WV 26451/Phone: 304-745-4568/Fax: 304-326-3700
___ Weston: 107 Staunton Drive, Weston, WV 26452/Phone: 304-269-2022/Fax: 304-269-2037
___ Pain Management: 597 Liberty Street, West Milford, WV 26451/Phone: 304-765-4444/Fax: 304-848-0890