WEST VIRGINIA

Declination for Release of Health Information

Participant Name:
Participant Address:
Participant Date of Birth (mm/dd/yy):

Receiving Entity Name: West Virginia WIC Program
Office of Nutrition Services

West Virginia Department of Health and Human Services
Receiving Entity Address: 350 Capitol Street, Room 519, Charleston WV 25301

Receiving Entity Telephone No. (304) 558-0030 Fax No. (304) 558-1541 Email: wvdhhrwic@wv.gov

I ("Participant") **DO NOT** authorize my treating health care providers to release all health information from my medical records to the entity named above ("Receiving Entity") for the purpose of determining WIC eligibility and recertification. This Declination for Release of Health Information ("Declination") shall remain in effect from the date of signature below and for so long as the individual remains a WIC participant **or** authorization is given.

I understand the following:

1. I may revoke this Declination at any time by completing the Authorization for Release of Health Information "Authorization;"

2. My Declination will not affect any of my WIC services or benefits;

3. My health care providers will not condition treatment, payment, enrollment, or eligibility for benefits based on my signing this Declination;

4. This declination does not opt me out of the WVHIN; and

5. I am entitled to receive a copy of this declination; and

6. The Receiving Entity shall **NOT** access health records by electronic means via the West Virginia Health Information Network.

Printed Name of Participant : _____

Participant Signature: _____ Date: _____

If Participant is unable to consent
Printed Name of Participant Representative: _____

Signature of Participant's Representative: _____

Relationship to Participant : _____ Date: _____