Authorization for Release of Health Information

Patient Name:

Patient Address:

Patient 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 ("Patient") 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. I understand that this disclosure will include all medical information maintained by my health care providers and may include records concerning my mental health, substance abuse, and HIV/AIDS-related illnesses. This Authorization for Release of Health Information ("Authorization") shall remain in effect from the date of signature below and for so long as the individual remains a WIC participant.

I understand the following:

1. I may revoke this Authorization at any time by providing written notice to the West Virginia WIC at the above contact information; provided, however, such revocation will not affect any action taken by WIC or my health care providers in reliance on this Authorization before receipt of my written revocation;

2. I may opt out of this Authorization, and this 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 Authorization;

4. The information disclosed in this Authorization may be subject to re-disclosure and no longer protected by federal law; and

5. I am entitled to receive a copy of this Authorization.

6. The Receiving Entity shall access health records by electronic means via the West Virginia Health Information Network.

Printed Name of Patient: _____

Patient Signature: _____ Date: _____

If Patient is unable to consent, Printed Name of Patient's Representative: _____
Signature of Patient's Representative: _____

Relationship to Patient: _____Date: _____