West Virginia Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street – Room 251 – Charleston, WV 25301-3709

Authorization or Revocation to Use and/or Disclose Protected Health Information

Notice to Medicaid or CHIP Recipient or Legal Representative: *No faxed version of this form will be accepted; signature must be original*.

Your request for access to your protected health information (PHI) is only applicable to the information maintained by the State of West Virginia, Bureau for Medical Services (Medicaid and CHIP). If you would like access to your PHI maintained by any other Health Plan or Health Care Provider, a separate request must be submitted to that plan or provider.

Authorization Section:

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?_____

_____

_____

_____

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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**

Revocation Section:

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.**

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

_____ _____

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Instructions and Notice to Recipient of Disclosed PHI:

Important: After completing this form, make a copy for your records and mail the original form with your original signature to the BMS at the address below:

You may revoke this authorization at any time. To revoke this authorization:

- If you retained your copy of the original authorization form, simply fill in the "Revocation Section" at the bottom of the form, sign (must be in ink other than black), and mail the form to the following address:

  Bureau for Medical Services
  Attention: Privacy Officer
  350 Capitol Street, Room 251
  Charleston, WV 25301-3709

- If you do not have your copy of the original authorization form, contact the Bureau for Medical Services Privacy Officer at (304) 558-1700, Monday through Friday from 9:00 AM until 4:00 PM Eastern Standard Time. The Privacy Officer will locate the original authorization form and mail or fax a copy of the document to you or your legal representative. You or your legal representative will need to fill out the "Revocation Section" at the bottom of the form, sign (must be in ink other than black) and **mail** the document back to the Privacy Officer at the above address.

****Note:** A person or organization that receives your information (as a result of your specific instruction to the Bureau for Medical Services via this form) may have the legal right to disclose this information to other people or organizations without your knowledge or consent.

The West Virginia Bureau for Medical Services recommends that you carefully read the *Notice of Privacy Practices* included in this mailing or facsimile. The notice outlines specific ways that the Bureau for Medical Services may use or share your health information **without** your specific instruction or approval and outlines your specific rights concerning the protection of our health care information.

If you have questions concerning this form and need to contact the Bureau for Medical Services, please call: (304) 558-1700, Monday through Friday from 9:00 AM until 4:00 PM Eastern Time.