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 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). 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?_____

_____

_____

_____

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

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:**

_____ _____