UPMC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

IMPRINT PATIENT IDENTIFICATION HERE

I authorize _____ to release information from the record of:
Name of Facility/Person

_____ _____ _____ to
Patient Name | Birth Date | SSN/MR#

_____ ( ) _____ ( ) _____
Name of Facility/Person | Phone | Fax

_____
Facility/Person Address

for the purpose of **(PROVIDE A DETAILED DESCRIPTION)**: _____

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released **and** approximate date(s) of service (check all that apply):
   - ☐ Inpatient ☐ Emergency Dept. Dates: _____
   - ☐ Outpatient ☐ Physician Office/Clinic

I authorize the release of: (check all that apply) ☐ **Mental Health Information** ☐ **Drug and Alcohol Information, contained in the records indicated above.**

2. Specific information to be released (check all that apply):
   - ☐ Consults ☐ Medical History & Physical Exam ☐ Physician Orders
   - ☐ Discharge Summary/Instructions ☐ Medication Records ☐ Progress Notes
   - ☐ Laboratory Reports/Tests ☐ Operative Report ☐ Psychiatric/Psychological Eval
   - ☐ Mammography Report ☐ Pathology Report ☐ Radiology Report
   - ☐ Emergency Dept. Report ☐ EKG Report(s)
   - ☐ Other: _____

HIV-related information contained in the parts of the records indicated above will be release through this authorization unless otherwise indicated. ☐ **Do not release**

I understand that this Authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified below. No time frame may exceed one year after the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. **See side two of this form for additional patient rights and responsibilities.** If applicable, specify other expiration date/event here: _____

Date of Signature	Signature of Patient (14 years of age or older may authorize release of mental health information. A minor can authorize release of drug & alcohol treatment information without parental consent.)	Date of Signature	Signature of Parent, Legal Guardian or Authorized Representative* (complete below)
Date of Signature	Witness/Staff Member Signature		

***Authorized Representative's relationship and authority to act on behalf of patient:** _____

ORAL AUTHORIZATION (for persons physically unable to sign)
NOT Applicable to HIV Related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date	Witness #1	Date	Witness # 2

Additional Patient Rights and Responsibilities

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) UPMC and its staff/employees have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule (HIPAA), however, such information is always protected by the drug and alcoholic regulations.
- My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- UPMC cannot require me to sign the Authorization in order to receive treatment.
- In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or governmental officials shall be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
- A verbal request to revoke this authorization is sufficient for information protected under the drug and alcohol regulations.
- I am entitled to a copy of this completed Authorization form.

Copy of authorization must be provided to patients when authorization is initiated by UPMC and for all Drug and Alcohol Treatment Patients.

☐ Copy of authorization provided to patient

☐ Copy of authorization refused

Staff and Copy Service Use Only (Optional)

Staff/Copy Service Signature: _____

☐ I.D. Obtained ☐ Signature Checked ☐ Other _____

Type of I.D.: _____

☐ Fee $_____ ☐ No Fee

Records Release By: _____

Date Released: _____