

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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):

- | | | |
|---|--|---|
| <input type="checkbox"/> Consults | <input type="checkbox"/> Medical History & Physical Exam | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Discharge Summary/Instructions | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Laboratory Reports/Tests | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Psychiatric/Psychological Eval |
| <input type="checkbox"/> Mammography Report | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Radiology Report |
| <input type="checkbox"/> Emergency Dept. Report | <input type="checkbox"/> EKG Report(s) | |
| <input type="checkbox"/> Other: _____ | | |

HIV-related information contained in the parts of the records indicated above will be released 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 from 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 alcohol 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 Released By: _____

Date Released: _____