Patient Name: _____ Date of Birth: _____

Address: _____

_____

I have been a patient at your facility, or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way. The facility cannot require me to sign the authorization in order to receive treatment.

I, _____ hereby authorize

_____ to release records to:
(Name of Facility, Office or Clinic)

_____
(Name of Individual, Facility, Agency, School, or Entity to Receive Health Information)

_____
(Street Address)

_____
(City, State) (Zip Code) (Phone No.)

The following information or copies of: (place a check by types of records desired)

- ❑ Pertinent Documents (Face Sheet, Attestation, H&P, Consultations, Lab/Test Results, EKG's, OR Reports, Discharge Summary, ER Report)
- ❑ Discharge Summary ❑ Operative Reports ❑ Consultation ❑ H&P
- ❑ Progress Notes ❑ Radiology (x-ray, CT, MRI, etc.) ❑ Lab Results
- ❑ Emergency Department ❑ Outpatient/Clinic *(specify)* _____
- ❑ The above information and/or the entire Clinical Record **INCLUDING** HIV-related information, mental health, drug or alcohol treatment
- ❑ Entire Clinical Record **EXCLUDING** HIV-Related, mental health, drug or alcohol treatment
- ❑ Billing or other business records *(specify)*: _____
- ❑ Other *(specify)*: _____

from *(date)*: _____ to *(date)*: _____

Reason for Request:

- ❑ Continuing treatment ❑ Employer ❑ Insurance ❑ Study/Research ❑ Legal ❑ Disability
- ❑ I do not wish to disclose the reason
- ❑ Other _____

This authorization will expire in six months or: _____

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.

I understand that this authorization is subject to revocation at any time, except to the extent that Allegheny Health Network has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing and delivered to the Privacy Officer. 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. I understand that recipients may redisclose information which I have authorized them to receive and the information will no longer be protected by federal privacy regulations. If I am physically unable to sign, I may provide oral authorization if witnessed by two (2) staff members.

Patient or Representative Signature _____ Date _____ Time _____

If representative, give relationship and authority to act _____

Witness Signature _____ Date _____ Time _____

Witness Signature _____ Date _____ Time _____

❑ Copy accepted ❑ Copy refused

Allegheny Health Network

Patient Identification

1000

Authorization for Release of Protected Health Information

UPMC LIFE CHANGING MEDICINE

Authorization for Release of Protected Health Information

I authorize the following UPMC Facility(s):

- ☐ Presbyterian/Montefiore
- ☐ Shadyside
- ☐ South Side
- ☐ Passavant (McCandless)
- ☐ Passavant (Cranberry)
- ☐ McKeesport
- ☐ Magee-Women's
- ☐ East
- ☐ Northwest
- ☐ St. Margaret
- ☐ Mercy
- ☐ Horizon

to release information from the record of:

_____ : _____ : _____ **as described below to:**
Patient Name **Birth Date** **SSN/MRN**

_____ _____ _____
Facility/Person to receive records **Phone** **Fax**

_____
Street **City** **State** **Zipcode**

Please provide the patient's address (if different from above info) & phone number below:

_____ _____
Patient Address **Patient Phone Number**

Records are requested for the purpose of: ☐ Continuing Care/Medical Facility ☐ Legal ☐ Personal Use ☐ Insurance
(Please check one) ☐ Other: _____

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

1. Type of records to be released **and** date(s) of service (check all that apply):

☐ Inpatient - Dates: _____ ☐ Emergency Dept - Dates: _____
☐ Same Day Surgery - Dates: _____ ☐ Outpatient Testing - Dates: _____

2. Specific information to be released (check all that apply):

☐ Consultation Reports ☐ History & Physical Exam ☐ Physician Orders
☐ Discharge Summary ☐ Medication Administration Records ☐ Physician Progress Notes
☐ Laboratory Reports/Tests ☐ Operative Report ☐ Psychiatric/Psychological Evaluation
☐ Nurses Notes ☐ Pathology Report ☐ Radiology Report
☐ Emergency Department Report ☐ EKG Report(s) ☐ Rehabilitation Records
☐ Other, specify: _____

HIV and Mental Health information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release: ☐ **Drug/Alcohol** ☐ **HIV** ☐ **Mental Health (Psychiatric)**

I understand that this Authorization is effective for a period of 90 days from the date of 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 inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.)

Date of Signature **Signature of Authorized Representative**
Appropriate paperwork required

☐ Parent or Legal Guardian ☐ Power of Attorney
☐ Next of Kin of Deceased ☐ Executor of Estate

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

Please be aware that health care facilities are authorized by Pennsylvania State law to charge for the reproduction of medical records and that charges may be associated with this request. Requestors may be notified in advance of the amount due for the request and records will be sent upon receipt of payment.

UPMC LIFE CHANGING MEDICINE

Authorization for Release of Protected Health Information

Additional Patients 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 responsibilty or liability as a result of an redisclosure and (2) such information would no longer be protected by the Privacy Rule.
- 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 government 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.
- I am entitled to a copy of this completed Authorization form.

Please mail to:

UPMC Health Information Management Department
Release of Information
450 Melwood Avenue - Lower Level
Pittsburgh, PA 15213

UPMC LIFE CHANGING MEDICINE

For UPMC / Highmark Transition of Care Only

Authorization for Release of Protected Health Information

I authorize _____ **and/or the following UPMC hospital(s):**

Name of Physician Office or Clinic

☐ **East** ☐ **Magee-Womens** ☐ **McKeesport** ☐ **Mercy** ☐ **Passavant (Cranberry)** ☐ **Passavant (McCandless)**
☐ **Presbyterian/Montefiore** ☐ **Shadyside** ☐ **St. Margaret** ☐ **South Side**

to release information from the record of:

_____ : ___/___/___ : _____ : _____
Patient Name | **Birth Date** | **Last 4 digits of SSN** | **Patient's Email Address**

_____ _____ _____ _____
Street Address | **City** | **State** | **Zip Code**

as described below to:

_____ _____ _____ _____
Facility/Person to Receive Records | **Phone** | **Fax** | **Facility's Email Address**

_____ _____ _____ _____
Street Address | **City** | **State** | **Zip Code**

Send records via secured email to: ☐ **Self and Physician** ☐ **Physician only** ☐ **Self only**

Records are requested for the purpose of: ☒ Transfer of Care

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

1. Type of records to be released **and** date(s) of service (check all that apply):

☐ Inpatient - Dates:_____ ☐ Emergency Dept - Dates:_____
☐ Same Day Services - Dates:_____ ☐ Outpatient Testing - Dates:_____
☐ Office - Dates: _____

2. Specific information to be released (check all that apply):

☐ Consultation Reports	☐ History & Physical Exam	☐ Physician Orders
☐ Discharge Summary	☐ Medication Administration Records	☐ Physician Progress Notes
☐ Laboratory Reports/Tests	☐ Operative Report	☐ Psychiatric/Psychological Evaluation
☐ Nurses Notes	☐ Pathology Report	☐ Radiology Report
☐ Emergency Department Report	☐ EKG Report(s)	☐ Rehabilitation Records

☐ Other, specify: _____

HIV and Mental Health information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release: ☐ **Drug/Alcohol** ☐ **HIV** ☐ **Mental Health (Psychiatric)**

I understand that this Authorization is effective for a period of 90 days from the date of 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 inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.) | **Date of Signature** | **Signature of Authorized Representative** **Appropriate paperwork required*

☐ Parent or Legal Guardian ☐ Power of Attorney

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

A photostatic copy of this authorization shall be considered as valid and effective as the original.
Please note that emails will be sent via a secure and encrypted electronic system.

Additional Patients 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 an redisclosure and (2) such information would no longer be protected by the Privacy Rule.
- 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 government 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.
- I am entitled to a copy of this completed Authorization form.

Please return the completed authorization using one of the methods below:

Mail to:
PSD Health Information Management Department
3600 Meyran Avenue, Suite 9029
Pittsburgh, PA 15213

Fax:
412-647-8586

Email:
HIMROI@upmc.edu

Please call 412-864-2680 if you require assistance with completing this form.