INFORMATIONAL GUIDE

Authorization for Release of Protected Health Information

Patient Information:

- Full Name at Time of Visit
- Birth Date
- Social Security Number (*or* Medical Record Number)

Recipient Information:

For Physician Office/Medical Facility:

- Facility Name
- Address
- Phone Number
- Fax Number.

For Personal Use:

- Recipient Name
- Address
- Phone Number

1. Service Type and Date Range:

Select type(s) of records to be released **and** dates of service*.

Types of Services

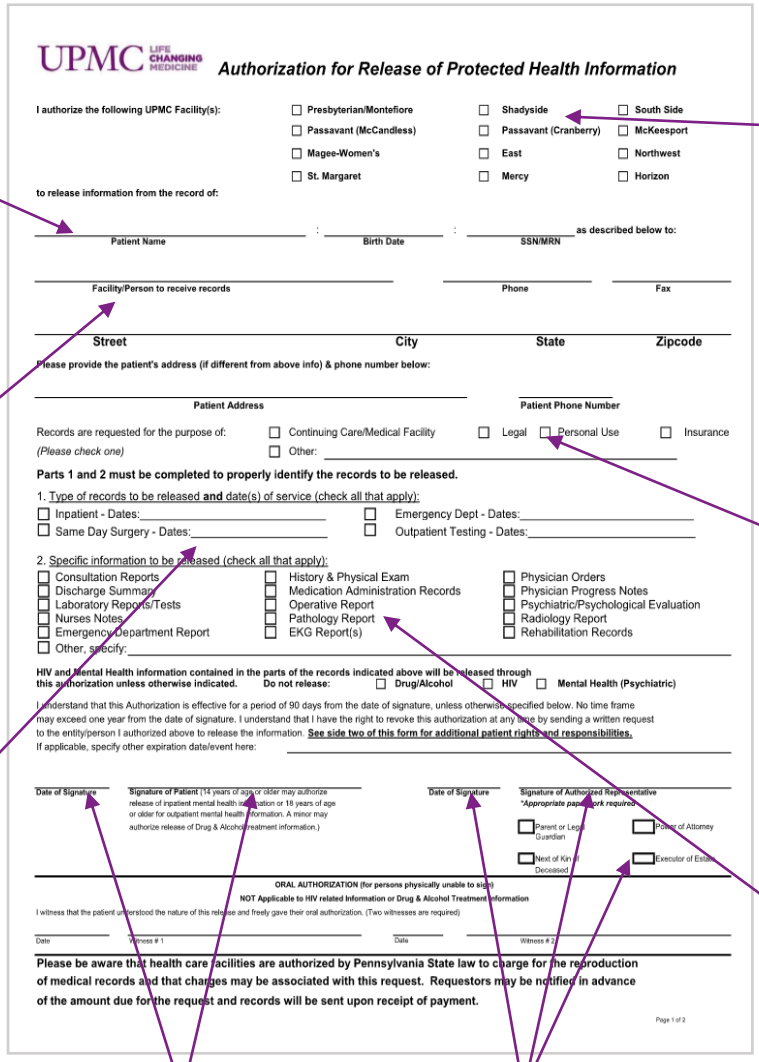
Inpatient: Admitted for treatment or surgery with overnight stay in hospital.
e.g. Intensive Care, Cardiology, Labor & Delivery.

Same Day Surgery: Treated and discharged same day.
e.g. Orthopaedic procedures, hernia repairs.

Emergency Dept: Treatment in Emergency Department.

Outpatient Testing: Not admitted to hospital.
e.g. Lab tests, X-rays, EKGs.

**If patient dates of service are unknown, approximate by month and/or year.*



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:

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

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 if 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.

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Authorize Facility(s):

Select UPMC hospital(s) where patient was seen.

Note: This form does not apply to non-hospital records including those from physician offices and urgent care centers.

Purpose for Release:

Send to Patient/Patient Representative:

- "Personal Use"

Send to Physician Office/ Medical Facility:

- "Continuing Care/Medical Facility"

Send to Insurance Company:

- "Insurance"

Send to Legal Group:

- "Legal"

2. Documents to Be Released:

Check specific report(s)/ records to be released that correspond with dates of service.

Date, Signature and Additional Documentation:

The patient or patient representative must sign **and** date the authorization.

If signed by a patient representative, a description of the authority to act for the individual is required. The authorized representative should choose one of the boxes above and provide appropriate documentation. If the patient is deceased, a copy of Executor of Estate papers must be included with the request. If the patient is living, a copy of Power of Attorney paperwork or other letter of representation must be provided.

Research requests should be directed to the Center for Assistance in Research website at www.eresearch.pitt.edu
Inquiries for "letter form of medical necessity" should be sent to the UPMC billing department at 2 Hot Metal Street, Quantum One, Pittsburgh, PA 15203.