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**
- ☐ **Kidney Transplant Center**

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.