



UPMC | University of Pittsburgh Medical Center

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize \_\_\_\_\_ to release information from the record of:

\_\_\_\_\_ Name of Facility/Person

\_\_\_\_\_ as described below to

\_\_\_\_\_ Patient Name      \_\_\_\_\_ Birth Date      \_\_\_\_\_ SSN/MR#

\_\_\_\_\_ Name of Facility/Person      \_\_\_\_\_ Phone      \_\_\_\_\_ Fax

\_\_\_\_\_ Facility/Person Address

Records are requested 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; Dates: \_\_\_\_\_  Emergency Dept; Dates: \_\_\_\_\_
- Outpatient; Dates: \_\_\_\_\_  Physician Office/Clinic; Dates: \_\_\_\_\_
2. Specific information to be released (check all that apply):
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Consultation Reports     | <input type="checkbox"/> Medical History & Physical Exam   | <input type="checkbox"/> Physician Orders               |
| <input type="checkbox"/> Discharge Summary        | <input type="checkbox"/> Medication Administration 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"/> Discharge Instructions         |
| <input type="checkbox"/> Other, specify: _____    |  |   |

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

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: \_\_\_\_\_

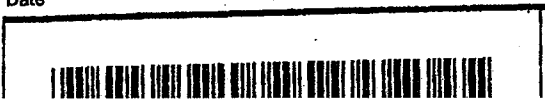
Date of Signature _____	Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.) _____	Date of Signature _____	Signature of Parent, Legal Guardian or Authorized Representative* (complete below) _____
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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 \_\_\_\_\_





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Date of Signature _____	Witness/Staff Member Signature _____
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Date _____	Witness #1 _____	Date _____	Witness #2 _____
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