

# UPMC Aesthetic Plastic Surgery Center

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

Name of Facility/Person

\_\_\_\_\_  
Patient Name : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ : \_\_\_\_\_ as described below to

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.

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: \_\_\_\_\_

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

Consultation Reports

Medical History &

Physician Orders

Discharge Summary

Physical Exam

Progress Notes

Laboratory Reports/  
Tests

Medication

Psychiatric/

Administrative Records

Psychological Eval

Mammography Report

Operative Report

Radiology Report

Emergency Dept. Report

EKG Report(s)

Discharge Instructions

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 30 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 dates/events here: \_\_\_\_\_.

\_\_\_\_\_  
Date of Signature **X**  
Signature of Patient (14 years or older may authorize release of inpatient mental health information of 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment Information.)

\_\_\_\_\_  
Date of Signature **X**  
Signature of Parent, Legal Guardian or Authorized Representative\* (Complete Below)

\_\_\_\_\_  
Date of Signature **X**  
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

# UPMC Aesthetic Plastic Surgery Center

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### **Additional Patient Rights and Responsibilities**

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- 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.
- 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.
- I am entitled to a copy of this completed Authorization form.

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### **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 patients
- Copy of Authorization refused

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### **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: \_\_\_\_\_