UPMC LIFE CHANGING MEDICINE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize the following UPMC facilities to release information from the record of:

Facilities:

☐ Altoona ☐ Bedford ☐ Divine Providence ☐ Hamot ☐ Lock Haven
☐ Muncy ☐ Wellsboro ☐ Western Psychiatric Hospital ☐ Williamsport

Ambulatory Surgery Facilities:

☐ Altoona Surgery Center
☐ Surgery Center Lewisburg

Closed Facilities:

☐ Sunbury

_____ _____ _____ as described below to:
Patient Name **Birth Date** **Last 4 digits SSN**

_____ _____ _____
Facility/Person to Receive Records **Phone** **FAX**

Mailing address of facility or person to whom records are to be released:

_____ _____ _____ _____
Street **City** **State** **Zip Code**

A. Records are requested for the purpose of: ☐ Continuing Care/Medical Facility ☐ Legal ☐ Personal Use ☐ Insurance
(*Please check one):* ☐ Other: _____ ***Note: Purpose is not required for patient access.***

B. Disclosure Format ☐Paper ☐ CD ☐ FAX (Providers Only) _____ _____ ☐ Other:_____

Method Received ☐ US Mail ☐ In-Person Pickup ☐ FAX (Providers Only) *(fax number):* _____
☐ Email: _____ ☐ Direct Address:_____

C. Parts 1 and 2 below 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: _____ ☐ Physician Office/Clinic
☐ Same Day Surgery – Dates: _____ ☐ Outpatient – Dates: _____ ☐ Other _____

2. Specific information to be released (check all that apply): **** For Radiology Images, please contact location where test was performed***

☐ Abstract (H&P, Consult, Test Results, Discharge Summary)

☐ Allergies	☐ Emergency Department Report	☐ Operative Report	☐ Problem List
☐ Consultation Report	☐ History & Physical Exam	☐ Pathology Report	☐ Procedure List
☐ Diagnostic Tests (cardiology studies, ECHO, EEG, EMG, pulmonary function, audiology)		☐ Physician Office/Clinic	☐ Psych Evaluation
☐ Discharge Instructions	☐ Laboratory Report/Test	☐ Physician Orders	☐ Radiology Report*
☐ Discharge Summary	☐ Medication Administration Records	☐ Physician Progress Notes	☐ Rehabilitation Records
☐ EKG Report	☐ Nurses Notes		

☐ Other, specify: _____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. ☐ Do not release

A CHECK MARK IS REQUIRED to release information from a licensed mental health facility, licensed drug and alcohol facility

☐ Drug/Alcohol **☐ 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 & outpatient mental health information from a licensed facility. A minor can authorize release of Drug & Alcohol treatment information from a licensed facility.

_____ _____
Date of Signature **Signature of Authorized Representative**

Appropriate paperwork required :

☐ Parent or Legal Guardian (copy of guardianship order attached)
☐ Power of Attorney (copy attached)
☐ Next of Kin of Deceased (copy of death certificate attached)
☐ Executor of Estate (letter of administration or testamentary attached)

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 LIFE CHANGING MEDICINE

Authorization for Release of Protected Health Information

Additional Patient Rights and Responsibilities

Please be aware that health care facilities are authorized by Pennsylvania State law to charge for 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.

- 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 a 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. To revoke your Authorization, please send your request in writing to the facility listed on the front of this form.
- UPMC will not condition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization.
- By signing this authorization, the patient/requestor acknowledges and understands the risk associated with the communication of emails between UPMC and the recipient and consent as outlined herein, as well as other instructions that UPMC may impose to communicate via email.
- I am entitled to a copy of this completed Authorization form.