FOR UPMC / HIGHMARK TRANSITION OF CARE

INFORMATIONAL GUIDE *for Completing the Authorization for Release of Protected Health Information Form*

Patient Information:
- Full Name at Time of Visit
- Birth Date
- Last 4 digits of Social Security Number
- Email Address
- Mailing Address

Recipient Information:
For Physician Office/Medical Facility:
- Facility Name
- Address
- Phone and Fax Number
- Email Address

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.

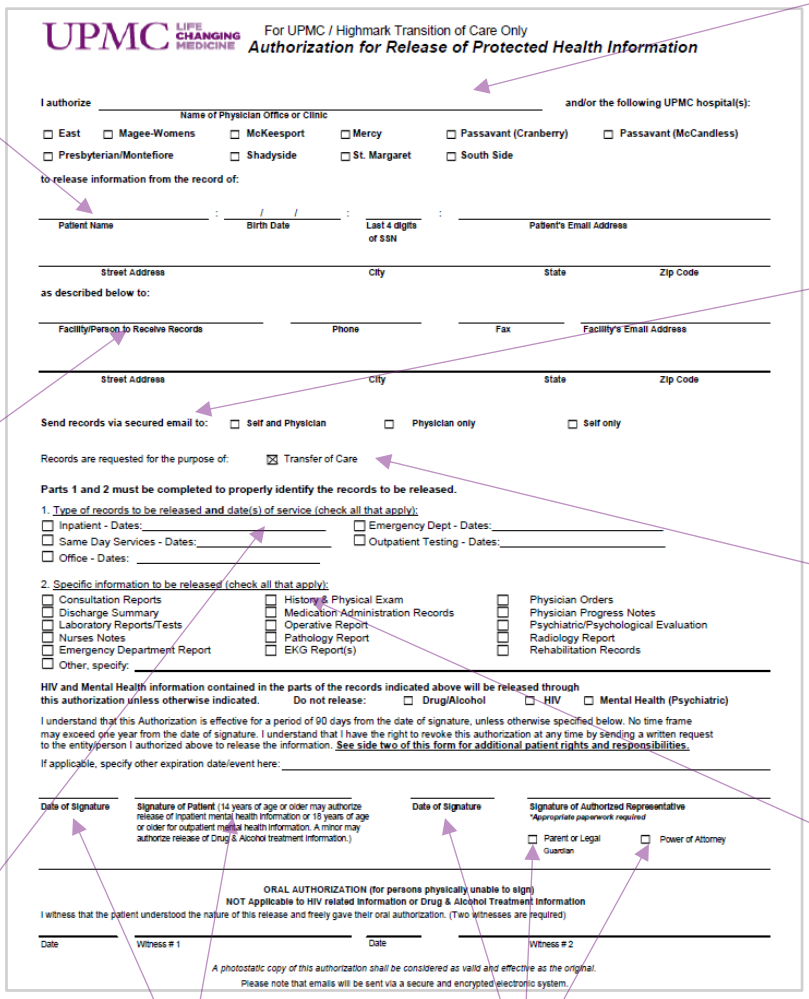
Same Day Surgery: Treated and discharged same day. e.g. Orthopaedic procedures, hernia repairs.

Emergency Dept: Treatment in Emergency Department.

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

Office: Physician office or clinic.

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



UPMC LIFE CHANGING MEDICINE — For UPMC / Highmark Transition of Care Only

Authorization for Release of Protected Health Information

I authorize _____ and/or the following UPMC hospital(s):
Name of Physician Office or Clinic

☐ East ☐ Magee-Womens ☐ McKeesport ☐ Mercy ☐ Passavant (Cranberry) ☐ Passavant (McCandless)
☐ Presbyterian/Montefiore ☐ Shadyside ☐ St. Margaret ☐ South Side

to release information from the record of:

Patient Name : Birth Date : Last 4 digits of SSN : Patient's Email Address

Street Address City State Zip Code

as described below to:

Facility/Person to Receive Records Phone Fax Facility's Email Address

Street Address City State Zip Code

Send records via secured email to: ☐ Self and Physician ☐ Physician only ☐ Self only

Records are requested for the purpose of: ☒ Transfer of Care

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 Services - Dates: ☐ Outpatient Testing - Dates:
☐ Office - 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

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

A photostatic copy of this authorization shall be considered as valid and effective as the original.
Please note that emails will be sent via a secure and encrypted electronic system.

Authorize Office or Hospital(s):
Name the office or select UPMC hospital(s) where patient was seen.

Send Records via Secured Email:
Select the intended recipient of the records, which will be sent secured to the email address provided above.

Purpose for Release:
Please note that this release is to be used only for transfer of care.

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.

For Assistance with Completing the Form:
Please contact UPMC's release of information team at 412-864-0854

To Check on the Status of Your Request:
Please contact HealthPort's Customer Service Department at 866-425-0174