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.

Additional Patients Rights and Responsibilities

- 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 responsibilty or liability as a result of an 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.
- 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 government 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.

Please return the completed authorization using one of the methods below:

Mail to:
PSD Health Information Management Department
3600 Meyran Avenue, Suite 9029
Pittsburgh, PA 15213

Fax:
412-647-8586

Email:
HIMROI@upmc.edu

Please call 412-864-0854 if you require assistance with completing this form.