



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

- Checkboxes for hospital locations: East, Magee-Womens, McKeesport, Mercy, Passavant (Cranberry), Passavant (McCandless), Presbyterian/Montefiore, Shadyside, St. Margaret, South Side.

to release information from the record of:

Form fields for Patient Name, Birth Date, Last 4 digits of SSN, Patient's Email Address, Street Address, City, State, Zip Code.

as described below to:

Form fields for 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: [x] 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):

- Checkboxes for Inpatient, Same Day Services, Office, Emergency Dept, Outpatient Testing with date fields.

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

- Checkboxes for various record types: Consultation Reports, Discharge Summary, Laboratory Reports/Tests, Nurses Notes, Emergency Department Report, Other, History & Physical Exam, Medication Administration Records, Operative Report, Pathology Report, EKG Report(s), Physician Orders, Physician Progress Notes, Psychiatric/Psychological Evaluation, Radiology Report, Rehabilitation Records.

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: \_\_\_\_\_

Signature lines for Date of Signature, Signature of Patient, Date of Signature, Signature of Authorized Representative, and checkboxes for 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)

Witness lines for 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 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.
- 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.

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**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 412-864-2680 if you require assistance with completing this form.