UPMC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize _____ to release information from the record of:
Name of Facility/Person

_____ _____ _____ to
Patient Name | Birth Date | SSN/MR#

UPMC MS CARE CENTER | (412) 641-6600 | (412) 692-2191
Name of Facility/Person | Phone | Fax

300 HALKET ST, SUITE 4500, PGH PA 15213
Facility/Person Address

for the purpose of **(PROVIDE A DETAILED DESCRIPTION)**: CONTINUING CARE

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released **and** approximate date(s) of service (check all that apply):

☐ Inpatient ☐ Emergency Dept. Dates: _____
☐ Outpatient ☐ Physician Office/Clinic

I authorize the release of: (check all that apply) ☐ **Mental Health Information** ☐ **Drug and Alcohol Information, contained in the records indicated above.**

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

☐ Consults	☑ Medical History & Physical Exam	☐ Physician Orders
☐ Discharge Summary/Instructions	☐ Medication Records	☑ Progress Notes
☑ Laboratory Reports/Tests	☐ Operative Report	☐ Psychiatric/Psychological Eval
☐ Mammography Report	☐ Pathology Report	☑ Radiology Report
☐ Emergency Dept. Report	☐ EKG Report(s)	(BRAIN, CERVICAL & THORACIC REPORT AND DISCS)
☐ Other: _____		

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

I understand that this Authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified below. No time frame may exceed one year after 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 mental health information. A minor can authorize release of drug & alcohol treatment information without parental consent.)	Date of Signature	Signature of Parent, Legal Guardian or Authorized Representative* (complete below)

Date of Signature	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