UPMC | University of Pittsburgh Medical Center

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

_____ : _____ : _____ as described below to
Patient Name Birth Date SSN/MR#

_____ ( ) _____ ( ) _____
Name of Facility/Person Phone Fax

_____
Facility/Person Address

Records are requested for the purpose of **(PROVIDE A DETAILED DESCRIPTION):** _____

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; Dates: _____
   - ☐ Outpatient; Dates: _____
   - ☐ Emergency Dept; Dates: _____
   - ☐ Physician Office/Clinic; Dates: _____

2. Specific information to be released (check all that apply):
   - ☐ Consultation Reports
   - ☐ Discharge Summary
   - ☐ Laboratory Reports/Tests
   - ☐ Mammography Report
   - ☐ Emergency Dept. Report
   - ☐ Other, specify: _____
   - ☐ Medical History & Physical Exam
   - ☐ Medication Administration Records
   - ☐ Operative Report
   - ☐ Pathology Report
   - ☐ EKG Report(s)
   - ☐ Physician Orders
   - ☐ Progress Notes
   - ☐ Psychiatric/Psychological Eval
   - ☐ Radiology Report
   - ☐ Discharge Instructions

HIV, Mental Health and Drug & Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release: ☐ HIV ☐ Mental Health (Psychiatric) ☐ Drug & Alcohol

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 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

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