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

_____ _____ _____to
Patient Name and Address | Birth Date | MR#/Last Four of SSN

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

_____
Facility/Person Address

for the purpose of (continuity of care, personal): _____

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
   - ☐ Outpatient
   - ☐ Harrisburg/CGOH ☐ WSH/Carlisle
   - ☐ Emergency Department Dates:_____
   - ☐ Physician Office/Clinic
   - ☐ York/Hanover ☐ Lancaster/Lititz

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

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

Disclosure Format *(Paper is default if not marked)*: ☐ Patient Pick-Up, ☐ US Mail – paper format, ☐ FAX, ☐ E-Mail – secure format, ☐ CD – secure electronic format, ☐ CD – images

By signing this authorization form, I understand that:

☐ Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

I understand that this Authorization is effective for a period of 1 year from the date of the 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 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

UPMC Pinnacle

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION

ADDITIONAL PATIENT 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 Pinnacle and its staff/employees have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule (HIPAA), however, such information is always protected by the drug and alcohol regulations.
- 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 Pinnacle 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 governmental 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.
- A verbal request to revoke this authorization is sufficient for information protected under the drug and alcohol regulations.
- I am entitled to a copy of this completed Authorization form.

Copy of authorization must be provided to patients when authorization is initiated by UPMC Pinnacle and for all Drug and Alcohol Treatment Patients.

☐ Copy of authorization provided to patient

☐ Copy of authorization refused

PATIENT IDENTIFICATION

UPMC Pinnacle

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION - GENERAL