

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 Emergency Department Dates: _____
 Outpatient Physician Office/Clinic
 Harrisburg/CGOH WSH/Carlisle 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 Medical History & Physical Exam Physician Orders
 Discharge Summary Medication Records Progress Notes
 Laboratory Reports/Tests Operative Report Psychiatric/Psychological Eval.
 Emergency Dept. Report Pathology Report Radiology/Imaging Report
 EKG Report(s)
- 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

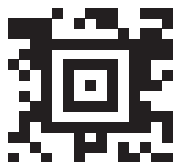
***Authorized Representative's relationship and authority to act on behalf of patient:** _____

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

UPMC Pinnacle

**AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION - GENERAL**

PATIENT IDENTIFICATION