UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

CHP-3005-0722

______________________________ ______________
Patient Name **Birth Date**

______________________________ ____________ ____________
Facility/Person to Receive Records **Phone** **FAX**

____
Mailing address of facility or person to whom records are to be released:

______________________ ____________ ______ ________
Street **City** **State** **Zip Code**

A. Records are requested for the purpose of: ☐ Continuing Care/Medical Facility ☐ Legal ☐ Personal Use ☐ Insurance
(*Please check one):* ☐ Other: ______________________ ***Note: Purpose is not required for patient access.***

B. Disclosure Format ☐Paper ☐ CD ☐ FAX (Providers Only) *(fax number):* ____________ ☐ Other:______________

Method Received ☐ US Mail ☐ In-Person Pickup ☐ FAX (Providers Only*) (fax number)*: ______ ______________
☐ Email: ________________ ☐ Direct Address: __________________________

C. Parts 1 and 2 below 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):

☐ Inpatient – Dates: ________________ ☐ Emergency Dept- Dates: ________
☐ Same Day Surgery – Dates: ____________ ☐ Outpatient – Dates: __________ ☐ Other ________

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

☐ Abstract (H&P, Consult, Test Results, Discharge Summary)
☐ Allergies ☐ Emergency Department Report ☐ Operative Report ☐ Problem List
☐ Consultation Report ☐ History & Physical Exam ☐ Pathology Report ☐ Procedure List
☐ Diagnostic Tests (cardiology studies, ECHO, EEG, EMG, pulmonary function, audiology) ☐ Outpatient Evaluations ☐ Psych Evaluation
☐ Discharge Instructions ☐ Laboratory Report/Test ☐ Physician Orders ☐ Radiology Images
☐ Discharge Summary ☐ Medication Administration Records ☐ Physician Progress Notes ☐ Radiology Report*
☐ EKG Report ☐ Nurses Notes ☐ Rehabilitation Records
☐ Other, specify:

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

A CHECK MARK IS REQUIRED to release information from a licensed mental health facility, licensed drug and alcohol facility

☐ Drug/Alcohol **☐ 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: ______________________________

______________________ ______________________________
Witness Signature of patient or person authorized to consent for patient

________ ________ ______________________________
Date Time Relationship to patient if signer is not patient

I have explained to the person signing above all the information contained in this consent form. I have given no guarantee or assurance as to the results that may be obtained.

________ ________ ______________________________
Date Time Signature of physician

3005

Authorization for Release of Protected Health Information

Additional Patient Rights and Responsibilities

Please be aware that health care facilities are authorized by Pennsylvania State law to charge for reproduction of medical records and that charges may be associated with this request. Requestors may be notified in advance of the amount due for the request and records will be sent upon receipt of payment.

- 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. To revoke your Authorization, please send your request in writing to the facility listed on the front of this form.
- UPMC will not condition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization.
- 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.
- By signing this authorization, the patient/requestor acknowledges and understands the risk associated with the communication of emails between UPMC and the recipient and consent as outlined herein, as well as other instructions that UPMC may impose to communicate via email.
- I am entitled to a copy of this completed Authorization form.