

UNIVERSITY OF PITTSBURGH
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to release information from the record of
Name of School/Department/Unit

_____; _____;
Patient Name Birth Date

_____ as described below to _____.
SSN (last 4 digits)/MR# Name of Facility/Person

Facility/Person Address

Phone Fax

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

I authorize the release of: (check all that apply) Mental Health Information Drug and Alcohol Information
contained in the records below.

The records to be released (identify all that apply) are (please include approximate dates of service):

- | | | |
|---|---|---|
| <input type="checkbox"/> Inpatient Records | Dates: _____ | |
| <input type="checkbox"/> Outpatient Records | Dates: _____ | |
| <input type="checkbox"/> Emergency Records | Dates: _____ | |
| <input type="checkbox"/> Physician or Dentist Office/Clinic | Dates: _____ | |
| <input type="checkbox"/> Consults | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Psychiatric/Psychological Eval |
| <input type="checkbox"/> Discharge Summary/Instructions | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Laboratory Notes/Reports | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Mammography Report | <input type="checkbox"/> Physicians/Dentists Orders/Reports/Notes | _____ |
| <input type="checkbox"/> Medical History & Physical Exam | <input type="checkbox"/> Progress Notes | _____ |
- Research – Refer to IRB Guidance entitled, "HIPAA Privacy Rule Guidance for Researchers at the University of Pittsburgh and UPMC. Must be approved by University IRB as specified in the IRB approved research proposal.

HIV-related information contained in the parts of the record(s) indicated above will be released through this authorization unless otherwise indicated by an "X" in the following block: DO NOT RELEASE

I understand the following:

- A disclosure statement, as required by law, will accompany all records released. (See attached.)
- 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) the University 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.
- The University 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.

GENERAL AUTHORIZATION*

Patient/Individual Signature

Date

The above named Patient/Individual is unable to provide a signature due to:

Legal Representative Signature

Date

Relationship to Patient/Individual AND description of authority to act on behalf of Patient/Individual:

ORAL AUTHORIZATION – NOT APPLICABLE TO HIV-RELATED INFORMATION

I witness that the person understood the nature of this release and freely gave his/her oral authorization.
(Two witnesses are required).

Witness #1

Date

Witness #2

Date

* A minor may authorize if for Drug and Alcohol related; if for Behavioral Health, a patient/individual who is 14 or older shall authorize (inpatient records only).

A disclosure statement, as required by law, will accompany the records requested.

Office Use Only

Copy provided to Patient/Individual

Signature: _____