For Physician Office Use

INFORMATIONAL GUIDE *for Completing the*

Authorization for Release of Protected Health Information Form

Patient Information:
- Full Name at Time of Visit
- Birth Date
- Social Security Number/MRN

Recipient Information:
For Physician Office/Medical Facility:
- Facility Name
- Complete Address
- Phone and Fax Number

For Personal Use:
- Recipient Name
- Complete Address
- Phone Number

1. Service Type and Date Range:
Select type(s) of records to be released **and** dates of service*.

Types of Services:

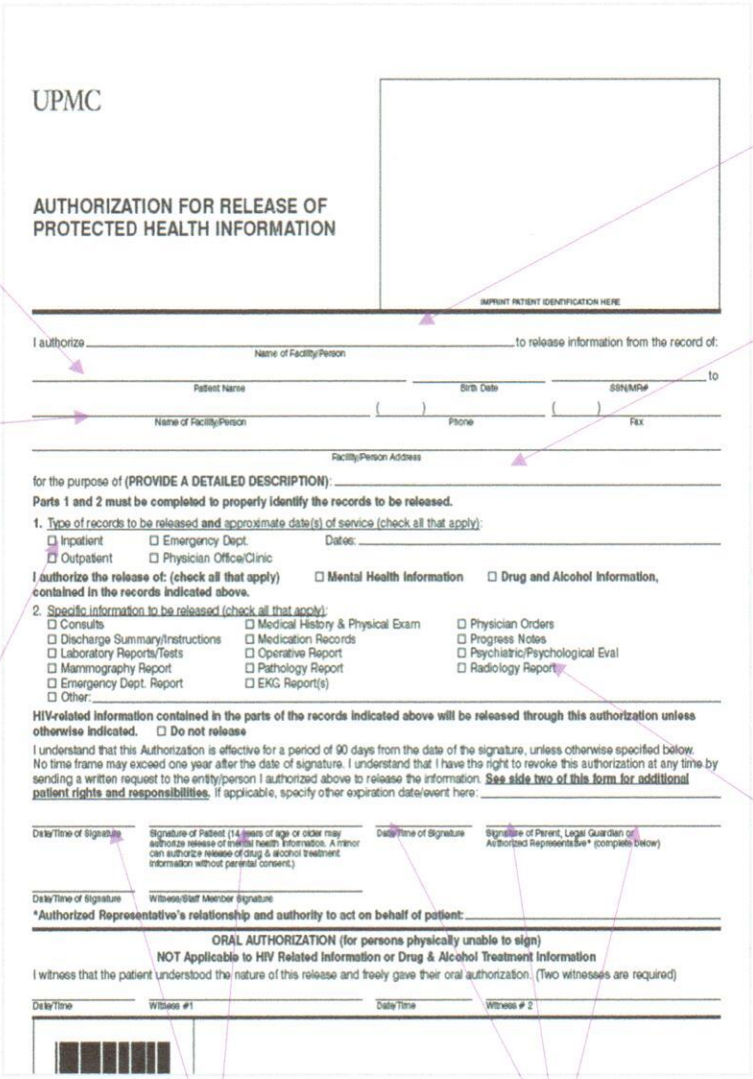
Physician's Office or Clinic: Records from a particular physician's visit or a range of visits or clinic visits.

Outpatient: Not admitted to hospital. e.g. Lab tests, X-rays, EKGs.

Inpatient: Please use Hospital ROI form.

Emergency Dept: Please use Hospital ROI form.

**If patient dates of service are unknown, approximate by month and/or year.*



UPMC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

IMPRINT PATIENT IDENTIFICATION HERE

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

_____ _____ _____ to
Patient Name | Birth Date | SSN/MR#

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

_____
Facility/Person Address

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 ☐ Emergency Dept. Dates: _____
☐ Outpatient ☐ Physician Office/Clinic

I authorize the release of: (check all that apply) ☐ **Mental Health Information** ☐ **Drug and Alcohol Information, 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/Instructions ☐ Medication Records ☐ Progress Notes
☐ Laboratory Reports/Tests ☐ Operative Report ☐ Psychiatric/Psychological Eval
☐ Mammography Report ☐ Pathology Report ☐ Radiology Report
☐ Emergency Dept. Report ☐ EKG Report(s)
☐ Other: _____

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

I understand that this Authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified below. No time frame may exceed one year after 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/Time 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/Time of Signature | Signature of Parent, Legal Guardian or Authorized Representative* (complete below)

Date/Time 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/Time | Witness #1 | Date/Time | Witness # 2

List the physician/office where services were rendered. (Office name preferred)

Purpose for Release:

Send to Patient/Patient Representative:
- "Personal Use

Send to Physician Office/Medical Facility:
- "Continuing Care/Medical Facility"

Send to Insurance Company
- "Insurance

Send to Legal Group
- "Legal"

2. Documents to Be Released:
Check specific report(s)/ records to be released that correspond with dates of service.

Date, Signature and Additional Documentation:
The patient or patient representative must sign **and** date the authorization.

If signed by a patient representative, a description of the authority to act for the individual is required. The authorized representative should choose one of the boxes above and provide appropriate documentation. If the patient is deceased, a copy of Executor of Estate papers must be included with the request. If the patient is living, a copy of Power of Attorney paperwork or other letter of representation must be provided.