UPMC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize UPMC-MONTEFIORE-PRESBYTERIAN-RADIOLOGY DEPARTMENT to release information from the record of:
Name of Facility/Person

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

_____ 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 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)

PHONE-412-648-6063
FAX------412-648-6097

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