

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#

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

