Policy (CS 30) Authorization for Release of Protected Health Information

SECTION I:

Patient/Individual Name: _____

Patient/Individual Date of Birth: _____

Patient Individual Medical Record Number: _____

Patient Individual Address: _____

_____

SECTION II:

I am authorizing the University of Pittsburgh _____ to release information from my medical record. Records are requested for the following purpose:

_____

I authorize the release of the following types of information (check all that apply)

☐ Medical Records ☐ Mental Health Information ☐ Drug and Alcohol Information

I authorize the release of this information from the following types of records (check all that apply)

☐ Inpatient Records
☐ Outpatient Records
☐ Emergency Records
☐ Physician or Dentist Office/Clinic
☐ Consults, Discharge/Summary Instructions
☐ Laboratory Notes/Reports
☐ Mammography Report
☐ Medical History & Physical Exam
☐ Medication Records
☐ Operative Report
☐ Pathology Report
☐ Physicians/Dentist's Orders/Reports/Notes
☐ Progress Notes
☐ Psychiatric/Psychological
☐ Evaluation
☐ Radiology
☐ Health Plan Information
☐ Other (please specify)
☐ Research (Please refer to the University of Pittsburgh Institutional Review Board Guidelines)

Please note that HIV-related information contained in the records indicated above will be released through this authorization unless otherwise indicated here:

☐ DO NOT RELEASE

SECTION III:

- I understand that a disclosure statement, as required by law, will accompany all records released

- I understand that release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- I understand that although applicable law may prohibit re-disclosure of these records, that it is possible that the facility/person that receives the records may re-disclose the information, therefore:
    - 1. The University and its employees have no responsibility or liability as a result of any re-disclosure, and
    - 2. Such information would no longer be protected by the HIPAA Privacy Rule, however, such information is always protected by applicable drug and alcohol regulations
- I understand that the University of Pittsburgh cannot require me to sign this authorization in order to receive treatment
- In accordance with 4 PA Code 255.5 (b), Drug and Alcohol treatment information to be released to judges, probation or parole officers, insurance companies, health or hospital plans, or government officials shall be restricted to the following:
    - 1. Whether or not the client is 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
- I understand my decision to revoke this 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
- I understand that my decision to revoke this 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
- I understand that a verbal request to revoke this authorization is sufficient for information protected under the drug and alcohol regulations
- I understand that I am entitled to ap copy of this completed authorization form

*Signature of Patient/Individual:_____ Date: _____

The above-named patient is unable to provide a signature due to: _____

Signature of Legal Representative: _____ Date: _____

Representative Relationship to Individual:_____

Description of Authority to act on behalf of Patient/Individual: _____

* 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).

UNIVERSITY OF PITTSBURGH INTERNAL USE ONLY

Date Received: _____

Received and Processed by:

Name: _____ Title/Position: _____

Covered Component: _____

Records Requested sent: Date Sent: _____

*For individuals requesting records from multiple schools/departments/units, please document date(s) request(s) forwarded to other facilities:

_____

_____

Signature of Authorized Component Employee: _____

Date: _____