ATTACHMENT B
POLICY 07-02-02
April 14, 2003

UNIVERSITY OF PITTSBURGH

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to release information from the record of
Name of Faculty/Person

_____; _____;
Patient Name Birth Date

_____ as described below to _____.
SSN/MR# Name of Facility/Person

_____
Facility Address

_____ _____
Phone Fax

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

The records to be released (identify all that apply) are (**please include approximate dates of service**):
_____Inpatient Records: Dates: _____; _____ Emergency Room Records; Dates: _____;

_____Outpatient Records; Dates: _____; _____ Physician Office/Clinic; Dates: _____;

_____Medical History & Physical Exam	_____Progress Notes	_____Psychiatric/Psychological Eval
_____Discharge Summary/Instructions	_____Laboratory Notes/Tests	_____Operative Report
_____Pathology	_____Medication Records	_____Other (specify): _____
_____Consults	_____Radiology	_____
_____Physicians Orders	_____Mammography Report	_____

HIV, Behavioral Health and Drug and Alcohol information contained in the parts of the record(s) indicated above will be released through this authorization unless otherwise indicated. Do not release: 9 HIV 9 Behavioral Health (Psychiatric) 9 Drug & Alcohol

I understand the following:

- That my health record(s) will not be released or obtained by the University unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information (Authorization).
- That the release of my health record(s) will be for the purpose stated on this form, and only those items checked off will be released.
- That the health record(s) released by the University may possibly be re-disclosed by the facility/ person that receives the record(s) and therefore: (1) University and its staff/employees have no responsibility or liability as a result of the re-disclosure; and (2) such information would no longer be protected by the Privacy Rule.
- That this Authorization is in effect for a period of 90 days from the date of signature, unless a specific time frame is documented; however, no time frame specified shall go beyond one year from the date of signature.
- That I have the right to revoke this Authorization form at any time by sending a written request to University's Privacy Officer, Vice Provost Robert F. Pack, 809 Cathedral of Learning, Pittsburgh, PA, 15260.
- That my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
- That my decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I may be liable for payment of the claim.
- That I am entitled to a copy of this completed Authorization form.

GENERAL AUTHORIZATION*

_____ _____
Patient Signature Date

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

_____

_____ _____
Legal Representative Signature Date

Relationship to Patient AND description of authority to act on behalf of patient:

_____

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 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 **9 Copy provided to patient** **Signature:**_____