Children's Hospital of Pittsburgh of UPMC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize **Children's Hospital of Pittsburgh of UPMC (CHP)** to release information from the record of

_____ ; _____ as described below to
Patient Name Birth Date

Name of Facility/Person: _____

Address: _____

Phone: _____ Fax: _____

Records are requested for the purpose of: ☐ Continuing care/Medical Facility ☐ Legal ☐ Personal Use
☐ Insurance ☐ Other: _____

Documentation can be released electronically if stored in an electronic media. ☐ ***Please check for release on CD***

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released and date(s) of service (*check all that apply*)

☐ Inpatient - Dates: _____ ☐ Outpatient Testing - Dates: _____

☐ Same Day Surgery - Dates: _____ ☐ Physician Office/Clinic - Dates: _____

☐ Emergency Dept. - Dates: _____

2. Information to be released:

☐ Problem List	☐ Pathology Report	☐ Laboratory Tests/Results
☐ Medication Lists	☐ Nurses Notes	☐ Radiology Report
☐ Allergies	☐ Physician Orders	☐ Radiology Images
☐ Procedure List	☐ Physician Progress Notes	☐ EKG Report(s)
☐ Emergency Department Report	☐ Discharge Instructions	☐ Diagnostic Tests *(cardiology studies, ECHO, EEG, EMG, pulmonary function, audiology)*
☐ History & Physical Exam	☐ Discharge Summary	
☐ Consultation Report	☐ Psychiatric Evaluation	
☐ Operative Report	☐ Rehabilitation Records	☐ Other: _____

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

I understand the following:

- 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 Children's Hospital of Pittsburgh of UPMC, Health Information Management Services at the following address: 4401 Penn Avenue, Pittsburgh, PA 15224.

See side two of this form for additional patient rights and responsibilities.

Date of Signature	Signature of Authorized Representative	Date of Signature	Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.)
	☐ Parent or Legal Guardian ☐ Power of Attorney ☐ Next of Kin of Deceased ☐ Executor of Estate		

Print Name of Authorized Representative **Print Name of Patient**

Authorized Representative Email **Patient Email**

ORAL AUTHORIZATION (for persons unable to sign)
NOT Applicable to HIV related information or Drug & Alcohol Treatment Information
I witness that the patient/parent/legal guardian understood the nature of this release and freely gave their oral authorization (Two witnesses are required)

Date	Witness #1	Date	Witness #2

Please be aware that heath care facilities are authorized by Pennsylvania State & Government Regulations to charge for the reproduction of medical records and that charges may be associated with this request.

ADDITIONAL PATIENT RIGHTS AND RESPONSIBILITIES

I understand the following:

- A disclosure statement, as required by law, will accompany all records released.
- That my/my child's health record(s) will not be released or obtained by CHP unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information.
- That the release of my/my child's 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 CHP may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) CHP 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 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/my child's medical care and I may be liable for payment of the claim.
- That CHP will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization or not.
- That I am entitled to a copy of this completed Authorization form.
- In accordance with Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or government officials shall be restricted to the following: 1) Whether the client is or is not 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.