



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

_____ as described below to
Patient Name Birth Date SSN/MR#

ExamOne
 800 NW Chipman Rd. / Suite 5900
 POBox 2340
 Lee's Summit, MO 64063-1149

Records are requested 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):

- | | |
|---|--|
| <input type="checkbox"/> Inpatient; Dates: _____ | <input type="checkbox"/> Emergency Dept; Dates: _____ |
| <input type="checkbox"/> Outpatient; Dates: _____ | <input type="checkbox"/> Physician Office/Clinic; Dates: _____ |

2. Specific information to be released (check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Medical History & Physical Exam | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Medication Administration Records | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Laboratory Reports/Tests | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Psychiatric/Psychological Eval |
| <input type="checkbox"/> Mammography Report | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Radiology Report |
| <input type="checkbox"/> Emergency Dept. Report | <input type="checkbox"/> EKG Report(s) | <input type="checkbox"/> Discharge Instructions |
| <input type="checkbox"/> Other, specify: _____ | | |

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 that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from 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 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.) _____	Date of Signature _____	Signature of Parent, Legal Guardian or Authorized Representative* (complete below) _____
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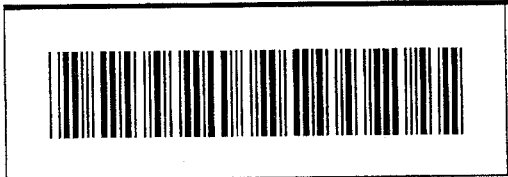
Date of Signature _____ Witness/Staff Member Signature _____

***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 _____
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Additional Patient Rights and Responsibilities

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) UPMC and its staff/employees have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- My decision to revoke the 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.
- My decision to revoke the 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.
- UPMC cannot require me to sign the Authorization in order to receive treatment.
- In accordance with 4 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 governmental 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.
- I am entitled to a copy of this completed Authorization form.

Copy of authorization must be provided to patients when authorization is initiated by UPMC and for all Drug and Alcohol Treatment Patients.

- Copy of authorization provided to patient
- Copy of authorization refused

Staff and Copy Service Use Only (Optional)

Staff/Copy Service Signature: _____

I.D. Obtained Signature Checked Other _____

Type of I.D.: _____

Fee \$ _____ No Fee

Records Released By: _____

Date Released: _____