UNIVERSITY OF PITTSBURGH
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the University of Pittsburgh at Bradford Student Health Services to release information from the record of

_____; _____;
Patient Name Birth Date

_____as described below to _____.
SSN (last 4 digits)/MR# Name of Facility/Person

_____
Facility/Person Address

_____ _____
Phone Fax

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

_____

I authorize the release of: (check all that apply) ☒ **Medical Records** ☐ **Mental Health Information**
☐ **Drug and Alcohol Information contained in the records below.**

The records to be released (identify all that apply) are (**please include approximate dates of service**):

☐ Inpatient Records Dates: _____
☐ Outpatient Records Dates: _____
☐ Emergency Records Dates: _____
☐ Physician or Dentist Office/Clinic Dates: _____

☐ Consults ☐ Medication Records ☐ Psychiatric/Psychological Eval
☐ Discharge Summary/Instructions ☐ Operative Report ☐ Radiology
☐ Laboratory Notes/Reports ☐ Pathology Report ☐ Immunization Records
☐ Mammography Report ☐ Physicians/Dentists Orders/Reports/Notes ☐ Other (specify): _____
☐ Medical History & Physical Exam ☐ Progress Notes _____
☐ Research – Refer to IRB Guidance entitled, "HIPAA Privacy Rule Guidance for Researchers at the University of Pittsburgh and UPMC. Must be approved by University IRB as specified in the IRB approved research proposal.

HIV-related information contained in the parts of the record(s) indicated above will be released through this authorization unless otherwise indicated by an "X" in the following block: ☐ DO NOT RELEASE

I understand the following:

- 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) the University 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 (HIPAA), however, such information is always protected by the drug and alcohol regulations.
- 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.

Patient Name: _____
(Last Name, Frist Name

- 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.
- The University 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.
- A verbal request to revoke this authorization is sufficient for information protected under the drug and alcohol regulations.
- I am entitled to a copy of this completed Authorization form.

GENERAL AUTHORIZATION*

_____ _____
Patient/Individual Signature Date

_____ _____
SHS Witness Date

The above named Patient/Individual is unable to provide a signature due to:

_____

_____ _____
Legal Representative Signature Date

Relationship to Patient/Individual AND description of authority to act on behalf of Patient/Individual:

_____

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/individual who is 14 or older shall authorize (inpatient records only).

A disclosure statement, as required by law, will accompany the records requested.