UPMC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

IMPRINT PATIENT IDENTIFICATION HERE

I authorize Children's Dermatology Services to release information from the record of:
Name of Facility/Person

Patient Name _____ Birth Date _____ SSN/MR# _____ to

Name of Facility/Person _____ ( ) Phone _____ ( ) Fax _____

Facility/Person Address _____

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):

O Inpatient O Emergency Dept. Dates: _____
O Outpatient O Physician Office/Clinic

I authorize the release of: (check all that apply) O Mental Health Information O Drug and Alcohol Information, contained in the records indicated above.

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

O Consults O Medical History & Physical Exam O Physician Orders
O Discharge Summary/Instructions O Medication Records O Progress Notes
O Laboratory Reports/Tests O Operative Report O Psychiatric/Psychological Eval
O Mammography Report O Pathology Report O Radiology Report
O Emergency Dept. Report O EKG Report(s)
O Other: _____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. O Do not release

I understand that this Authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified below. No time frame may exceed one year after 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/Time of Signature | Signature of Patient (14 years of age or older may authorize release of mental health information. A minor can authorize release of drug & alcohol treatment information without parental consent.) | Date/Time of Signature | Signature of Parent, Legal Guardian or Authorized Representative* (complete below)

Date/Time 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/Time | Witness #1 | Date/Time | Witness # 2