UPMC LIFE CHANGING MEDICINE

Dear Patient,

We understand your desire to have your records forwarded to another physician to continue your medical care. Enclosed please find a **Release of Information Request** from our **Neurology Outpatient Department** and directions for completion. As we want to help you obtain your records in the most efficient fashion, we have entered some of that information on the form for you. The following information can be released from our office: progress notes and examinations, laboratory studies, radiology reports, EEG, EMG, Nerve conduction studies, Evoked potentials, and sleep studies (if our physicians ordered the test). It is your responsibility to complete the remainder of the form correctly (examples included). Once the release is completed, please mail to the address listed below you may fax it to us at 412-692-4907.

Please note that our Neurology Department staff do not copy any records. The record copying is completed by the vendor **Healthport.** Once we receive your **Release of Information Request,** we enter it into our system. It will take several days for Healthport to process your request. If you need to know the status of your record retrieval, please contact Healthport at **866-425-0174.**

Inpatient Hospital Records If you require records from a hospitalization at UPMC , you may use the enclosed release marked **Inpatient** and phone **412-802-0100** for further directions.

Radiology Films We have also enclosed a **Release of Information** for your **MRI films** from the Radiology Department **of UPMC** should you need to have copies (images) of your radiology studies. This release can only be used if you have had your radiology studies (MRI, CT , Xrays) completed at UPMC. If your studies were completed at a non UPMC location, you will need to request the images from that imaging center. We are happy to forward your request to the Radiology Department if you include it with your record release. Otherwise please fax it to 412-648-6097. To check on the status of your film request, you may call the Radiology Film Library at **412-648-6063.**

It is the policy of UPMC to preserve the confidentiality and security of Protected Health Information (PHI) created, received, obtained, maintained, used, or transmitted by the UPMC, and to protect this information from unauthorized access or disclosure.

The Department of Neurology

Kaufmann Medical Building

3471 Fifth Avenue

Suite 810

Pittsburgh, PA 15213

412-692-4920 (P) 412-692-4907 (F)

UPMC OUTPATIENT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize UPP Dept of Neurology 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):

☒ Inpatient ☐ Emergency Dept. Dates:
☒ Outpatient ☐ Physician Office/Clinic

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

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

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

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. ☐ **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 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 of Signature | Signature of Parent, Legal Guardian or Authorized Representative* (complete below)

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

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

FAX 4126924907

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 (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.
- 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.
- 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.

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 Release By:_____

Date Released:_____

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Proper Completion of the UPMC Authorization

In many cases within the realm of Release of Information (ROI), a HIPAA compliant authorization is required to be properly executed by the patient or their representative. The following is a step by step guide to properly execute a UPMC Authorization. Each numbered item within this list corresponds to the enclosed labeled UPMC Authorization.

1) **The name of the facility/physician/practitioner authorized to release the requested medical records:** In this space list the name of the practice or practitioner to release the desired information. It is always better to utilize the practice name so that all providers within that practice will be included within the released record set.
2) **Patient Information:**
    a. **Patient Name:** The full name of the patient whose records are to be released.
    b. **Birth Date:** The correct date of birth of the patient whose records are to be released.
    c. **SSN/MR#:** The correct social security number of the patient whose records are to be released. Please note that a complete social security number is not required, but it is recommended that the patient/requestor supply at least the last four digits of the social security number.
3) **Name and Mailing Address of the Requestor:**
    a. **Name of Facility/Person; Phone; Fax:** The name of the person or organization to where the records are to be sent, a phone number for the requestor, and a fax number for the requestor. The phone and fax number of the requestor is not necessarily required for ROI, but in instances of clarification or expediting a request these items help.
    b. **Facility/Person Address:** The complete mailing address including the full street number, street name, suite/building number, city, state, and zip code must be contained within this space. If any of this information is missing, this will cause a delay in fulfilling the request or result in the authorization being rejected.
4) **Purpose:** This must answer the question "WHY" the records are being released. Examples include: continuation of care, litigation, insurance application, disability, personal, do not wish to disclose the reason/purpose
5) **Types of Records to be Released and Dates of Service:**
    a. **Type of Records:** The patient is to select the appropriate facility type authorized to release information: "Inpatient", "Outpatient", and/or "Physician Office/Clinic" boxes. While certain parts of these record types may not apply, it is a good habit to practice.
    b. **Dates:** List the specific date or date range of the records to be released. This can encompass a specific date or dates, a range of years (2,3,5 years), or All

c. **Mental Health Information and Drug and Alcohol Information:** In order to release this sensitive information, the appropriate box(es) must be checked. If left blank, no records containing this type of information can be released and may cause the authorization to be rejected.

d. **Specific Information to be Released:** This section specifies the different categories of documents found within the patient chart that may be released via the request. The patient/requestor should be encouraged to check off the following boxes correlating to the information they would liked to be released:

- **Laboratory Reports/Tests**
- **Mammography Report**
- **Medical History & Physical Exam**
- **Medication Records**
- **Operative Report**
- **Pathology Report**
- **EKG Report(s)**
- **Progress Notes**
- **Psychiatric/Psychological Eval**
- **Radiology Report**
- **Other** (This line can be utilized to encompass the type of records and dates of service for the request. Examples can include: All Records, Entire Chart, All Records for Specific Date Range).

e. **HIV-related information:** If the patient **desires** to have this information released from the chart, this box should be left blank. If the patient **does not desire** to have this information released, this box should be checked.

6) **Expiration of Authorization:** The authorization is valid for 90 days from the date of signature. The expiration date can be extended for any additional amount of time as specified by the patient up to but not to exceed 1 year from the date of signature. In order to extend the expiration date, the patient must write the new expiration date/event in the space provided. Please note that should the patient specify "No Expiration", the authorization will default to a 1 year expiration period.

7) **Date of Signature and Signature of the Patient/Representative:**
   a. **Date of Signature:** The date that the patient is signing the UPMC Authorization
   b. **Signature of Patient/Representative:** The signature of the patient or their legal representative

8) **Oral Authorization:** This section of the UPMC Authorization may be utilized in the event that the patient cannot make it into your office to complete the authorization. Two UPMC staff members must hear the patient give their verbal authorization over the phone and both UPMC staff members must date and sign in the spaces provided. Note: The form in its entirety must be read to the patient.

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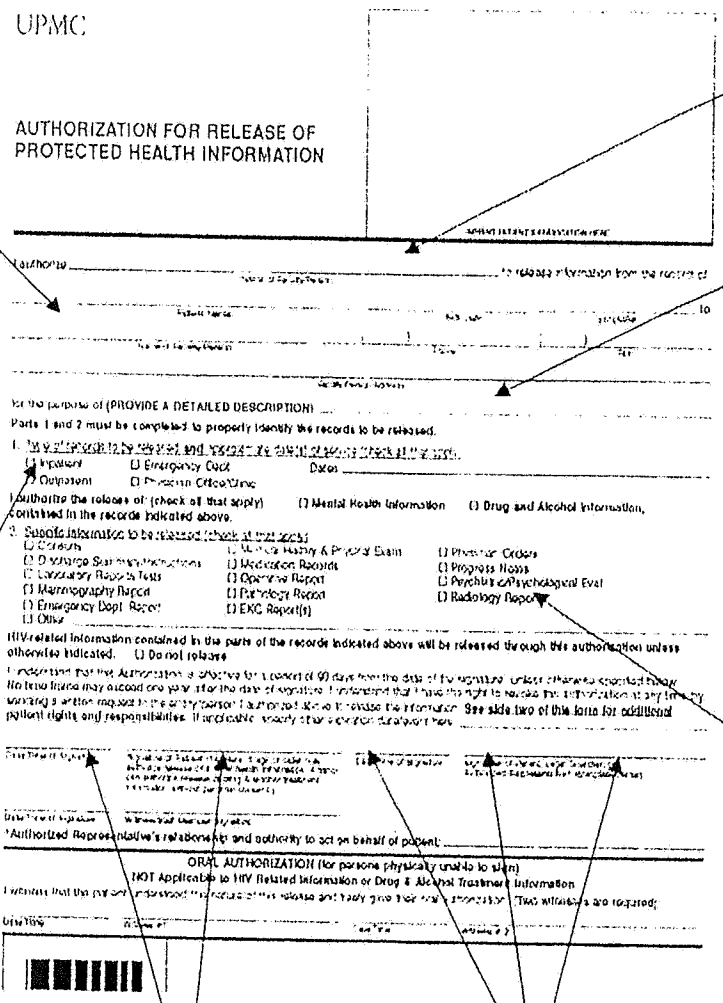
For Physician Office Use

INFORMATIONAL GUIDE *for Completing the Authorization for Release of Protected Health Information Form*

Patient Information:
- Full Name at Time of Visit
- Birth Date
- Social Security Number/MRN

Recipient Information:
For Physician Office/Medical Facility
- Facility Name
- Complete Address
- Phone and Fax Number

For Personal Use
- Recipient Name
- Complete Address
- Phone Number


UPMC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

List the physician/office where services were rendered. (Office name preferred)

Purpose for Release:

Send to Patient/Patient Representative:
- "Personal Use

Send to Physician Office/Medical Facility:
- "Continuing Care/Medical Facility"

Send to Insurance Company
- "Insurance

Send to Legal Group
- "Legal"

1. Service Type and Date Range:
Select type(s) of records to be released and dates of service*

Types of Services:

Physician's Office or Clinic: Records from a particular physician's visit or a range of visits or clinic visits.

Outpatient: Not admitted to hospital, e.g. Lab tests, X-rays, EKGs.

Inpatient: Please use Hospital ROI form.

Emergency Dept: Please use Hospital ROI form

**If patient dates of service are unknown, approximate by month and/or year*

2. Documents to Be Released:
Check specific report(s)/ records to be released that correspond with dates of service.

Date, Signature and Additional Documentation:
The patient or patient representative must sign and date the authorization.

If signed by a patient representative, a description of the authority to act for the individual is required. The authorized representative should choose one of the boxes above and provide appropriate documentation. If the patient is deceased, a copy of Executor of Estate papers must be included with the request. If the patient is living, a copy of Power of Attorney paperwork or other letter of representation must be provided.

UPMC INPATIENT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

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

_____ ( ) _____ ( ) _____
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):

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

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

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

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

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. ☐ 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 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 of Signature | Signature of Parent, Legal Guardian or Authorized Representative* (complete below)

_____ _____
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

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

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 (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.
- 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.
- 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.

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 Release By: _____

Date Released: _____

UPMC | University of Pittsburgh Medical Center

Radiology Film Request

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize **UPMC-MONTEFIORE-PRESBYTERIAN** to release information from the record of:
Name of Facility/Person

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

Name of Facility/Person ( ) Phone ( ) Fax

Facility/Person Address

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):
   - ☐ Inpatient; Dates:
   - ☐ Outpatient; Dates:
   - ☐ Emergency Dept; Dates:
   - ☐ Physician Office/Clinic; Dates:
2. Specific information to be released (check all that apply):
   - ☐ Consultation Reports
   - ☐ Discharge Summary
   - ☐ Laboratory Reports/Tests
   - ☐ Mammography Report
   - ☐ Emergency Dept. Report
   - ☐ Other, specify:
   - ☐ Medical History & Physical Exam
   - ☐ Medication Administration Records
   - ☐ Operative Report
   - ☐ Pathology Report
   - ☐ EKG Report(s)
   - ☐ Physician Orders
   - ☐ Progress Notes
   - ☐ Psychiatric/Psychological Eval
   - ☒ Radiology Report DISK
   - ☐ Discharge Instructions

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)

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

UPMC
Montefiore Hospital
200 Lothrop Street
Suite NE516
Pittsburgh, PA 15213

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FAX------412-648-6097