UPMC

UPP Department of Neurology
Kaufmann Medical Building
3471 Fifth Avenue, Suite 810, Pittsburgh, PA 15213
Telephone (412)692--4920 Fax (412)692-4907

Date

Dear

You are receiving this letter as you have made a request for our department to complete paperwork for you. In order for our office staff to complete any medical or insurance form or letter request, we need to inform you of our office procedures for handling such paperwork. The Neurology Department requires that you complete an *Authorization for Release of Protected Health Information* form (enclosed) so that we can legally share information regarding your medical condition with the person/ company requesting such information.

A fee will be charged by our office to complete your request. A fee schedule is also enclosed (on the other side of this letter). We charge fees for forms or letters as this work is uncompensated and creates additional work for our staff especially when requested outside of your scheduled appointment.

We will complete your request upon receipt of payment and completion of all forms. (Form fee and Release form). Once the forms are completed, we mail the form or letter to the requesting individual or company unless you state otherwise. A copy will be mailed to you for your records.
If you require this form to be completed sooner that 4 weeks, please schedule an appointment with our physician assistant Ryan Orie PA-C by calling 412-692-4920 and press number 1.

Please call _____should you have any questions at _____.

Sincerely

The Department of Neurology

UPMC

UPP Department of Neurology
Kaufmann Medical Building
3471 Fifth Avenue, Suite 810, Pittsburgh, PA 15213
Telephone (412)692-4920 Fax (412)692-4907

Please see the form fee schedule below. Allow at least 4 weeks from receipt of this form for processing.

Patient Name:_____

Date of Birth:_____

Physician:_____

Todays Date:_____

Fee Schedule 10.00 per side of requested form

Payment Type:

- o Cash
- o Check

*Please make checks payable to **'UPP Department of Neurology"*** TOTAL DUE ____

Please note FMLA forms are 20.00

Please be sure that you:

- o Completed this form
- o Include a completed and signed Authorization Release of Information Form
- o Include your payment for each form or letter that you are requesting

Internal Use Only:

Payor	
BU	
Account	
Dept	
Provider	
Description	
Amount Due	
Check #	

UPMC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize **UPMC PHYSICIANS DEPARTMENT OF NEUROLOGY** to release information from the record of:
Name of Facility/Person

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

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

X _____
Facility/Person Address

for the purpose of (**PROVIDE A DETAILED DESCRIPTION**): completion of disability forms

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):

D Inpatient D Emergency Dept Dates: X _____
D Outpatient D Physician Office/Clinic

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

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

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

D Other: _____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. D 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 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: _____

X _____ | X _____ | _____ | _____
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 AUTHORIZATIO& (for persons physically unable to sign)
&OT 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

0176-01-U