

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Witness # 1

Date

Patient Name

Medical Record Number

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I hereby authorize Children's Hospital of Pittsb	ourgh (CHP) to release	information from the	record of
Patient Name		;	Birth Date as described below to
Name of Facility/Person:			
Address:			
Phone:			
Records are requested for the purpose of:			
	_	er:	2 i dicental eco
Documentation can be released electronically	y if stored in an electro	onic media. 🖂 🖂	Please check for release on CD
Parts 1 and 2 must be completed to properly	identify the records to		rease check for release on OD
1. Type of records to be released and date(s) of	service (check all that a	apply)	
☐ Inpatient – Dates:		□ Outpatient Testing – Dates:	
☐ Same Day Surgery – Dates:		☐ Physician Office/Clinic – Dates:	
☐ Emergency Dept. – Dates:			
I authorize the release of: (check all that app	oly)	alth / Abuse Informa	tion ☐ Drug and Alcohol Information,
<ul><li>contained in the records indicated above.</li><li>2. Information to be released:</li></ul>			
□ Problem List	☐ Pathology Report		☐ Laboratory Tests/Results
☐ Medication Lists	☐ Nurses Notes		☐ Radiology Report
☐ Allergies	☐ Physician Orders		☐ EKG Report(s)
☐ Procedure List	☐ Physician Progress Notes		☐ Diagnostic Tests
☐ Emergency Department Report	☐ Discharge Instructions		(cardiology studies, ECHO, EEG, EMG,
<ul><li>☐ History &amp; Physical Exam</li><li>☐ Consultation Report</li></ul>	<ul><li>☐ Discharge Summa</li><li>☐ Psychiatric Evalua</li></ul>		pulmonary function, audiology)
☐ Operative Report	☐ Rehabilitation Rec		☐ Other:
no time frame specified shall go beyond o  That I have the right to revoke this Authoriz Information Management Services at the formation of the services are the formation of the services at the formation of the services are the services at the formation of the services are the services at the formation of the services are the	iod of 90 days from the ne year from the date o zation form at any time I	date of signature, un f signature. by sending a written i Penn Avenue, Pittsbu	less a specific time frame is documented; however, request to Children's Hospital of Pittsburgh, Health urgh, PA 15224.
Date of Signature Signature of Authorized Representative		Date of Signature	Signature of Patient (14 years of age or older may authorize
☐ Parent or Legal Guardian ☐ Power of Attorney ☐ Next of Kin of Deceased ☐ Executor of Estate			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.)
Print Name of Authorized Representative		Print Name of Patient	
Authorized Representative Email		Patient Email	
NOT Applical I witness that the patient/parent/legal guardian understood	ORAL AUTHORIZATION (f ble to HIV related information I the nature of this release an	n or Drug & Alcohol Treat	ment Information

Date

Witness #2



3005



## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name

Medical Record Number

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Birthdate

Please be aware that health care facilities are authorized by Pennsylvania State & Government Regulations to charge for the reproduction of medical records and that charges may be associated with this request.

## ADDITIONAL PATIENT RIGHTS AND RESPONSIBILITIES

I understand the following:

- A disclosure statement, as required by law, will accompany all records released.
- That my/my child's health record(s) will not be released or obtained by CHP unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information.
- That the release of my/my child's health record(s) will be for the purpose stated on this form, and only those items checked off will be released.
- That the health record(s) released by CHP may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) CHP
  an its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by
  the Privacy Rule.
- That my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the
  date of my request to revoke the Authorization
- That my decision to revoke the Authorization may result in my insurance company not being able to pay for my/my child's medical care and I may be liable for payment of the claim.
- That CHP will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization or not.
- That I am entitled to a copy of this completed Authorization form.
- In accordance with 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 government 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 that relapsed into drug or alcohol abuse and the frequency of such relapse.