UPMC AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PLEASE COMPLETE THE FIRST TWO LINES AND THE BOTTOM DATE AND SIGNATURE LINES AND SUBMIT THIS FORM TO YOUR DOCTOR

I AUTHORIZE _____TO RELEASE INFORMATION FROM THE RECORD OF:
HEALTH CARE PROVIDER

_____to
PATIENT NAME BIRTH DATE SSN/MR#

Sherwood Oaks – John Sterling or Betty Wright (724) 776-8544 (724) 776-8468
NAME OF FACILITY/PERSON PHONE FAX

100 Norman Drive Cranberry Twp., PA 16066
FACILITY/PERSON ADDRESS

For the purpose of (PROVIDE A DETAILED DESCRIPTION): **Application for Residency**

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):
   _x_ Inpatient _x_ Emergency Dept. Dates:_____
   _x_ Outpatient _x_ Physician Office/Clinic (Please send the last year of records to the present time)

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): **MUST INCLUDE PHYSICIAN NOTES**

_x_Consults	_x_Medical History & Physical Exam	_x_Physician Orders
_x_Discharge Summary/Instructions	_x_Medication Records	_x_Progress Notes
_x_Laboratory Reports/Tests	_x_Operative Report	_x_Psychiatric/Psych. Eval.
_x_Mammography Report	_x_ Pathology Report	_x_ Radiology Report
_x_Emergency Dept. Report	_x_EKG Report(s)	

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 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. If applicable, specify other expiration date/event here:
_____

X_____	X_____	_____	_____
Date of Signature	Signature of patient (14 years 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)
X_____	X_____		
Date of Signature	Witness/Staff Member Signature		

***Authorized Representative's relationship and authority to act on behalf of patient:_____**