UPMC LIFE CHANGING MEDICINE *HAMOT*

# Authorization for Disclosure of Health Information

IMPRINT PATIENT IDENTIFICATION HERE

**Section A (Required) Full Patient Name**_____ **Date of Birth** _____/_____/_____

Please select one: **(CHOICE 1) I authorize UPMC Hamot to disclose my health information as described below.**

**(CHOICE 2) I am the patient (or the patient's legal guardian, attorney-in-fact, etc.) and seek access to my own records.**

**(CHOICE 3) I authorize UPMC Hamot to receive the information described below, from:**

***Name of Entity/Person Authorized to Disclose Information_*** _____

**Section B (Required only if Choice 2 is selected in section A) If this is a request to provide records directly to the patient, please select one:**

____ I would like you to send a copy of these records to me at my address listed below. (Advance payment will be required.)

____ The following person will pick up a copy of these records at the Medical Records Office (Payment required at pick-up.*)_____

____ I would like to make an appointment to look at these records at the Medical Records Office.

(*The payment requirement may be waived when a patient is picking up and hand delivering records to another healthcare provider for further treatment. If this is your intention, please provide the name, address, and telephone number of the healthcare provider who will ultimately be receiving the records, in the section below.)

**If you are seeking records other than hospital records, please list each UPMC Hamot facility/office from which you desire to receive the described information:**_____

(NOTE If you listed any facility/office other than UPMC Hamot, records may need sent from different locations, so separate charges may apply.If blank, only UPMC Hamot records will be searched.

**Section C (Required) Name of person/entity who will receive information**_____

**Address**_____ **Telephone (_____)_____-_____**

**Purpose for Disclosure of Information**_____

**Description of Specific Information permitted to be disclosed (include dates where possible)**_____

_____

I specifically authorize the disclosure of the following type(s) of information, if it is included within the information requested above:

____Mental Health(initials) _____ ____ Drug and/or Alcohol Abuse/Treatment(initials)_____ ____ HIV Status(initials) _____

**This Authorization will expire within 90 days unless otherwise stated**_____

• I understand that I have the right to revoke this Authorization at any time. I may not revoke it to the extent that the entity disclosing the information has already relied upon it. In order to revoke this Authorization, I understand that I revoke it in writing to UPMC Hamot's Health Information Management Department, where it involves UPMC Hamot records. (Revocation forms are available at the Health Information Management Department.) Where it involves another entity's records, I must revoke it in writing to the entity disclosing the records. • I understand that the information disclosed under this Authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy protections provided to me under the privacy laws that protect health information. (I understand, however, that re-disclosure of mental health, drug and/or alcohol abuse/treatment, or HIV information is specifically prohibited under Pennsylvania and/or Federal law. • I understand that Hamot may not require that I sign this Authorization in order to obtain treatment. • I understand that I have a right to request to inspect the information disclosed, or to get a copy at my expense, from the entity that I have authorized to disclose the information. **I have read this Authorization, or had it explained to me, and I understand its contents.**

**Signature** _____ **Date** _____/_____/_____ **Time** _____:_____

**Daytime Telephone (_____)_____-_____**

If this Authorization is signed by the patient's legal representative, the following is the legal basis for his/her authority to act for the individual:

____ Power of Attorney *(copy attached)* ____ Guardianship Order *(copy attached)* ____ Parent of Minor ____Executor/Administrator *(short certificate attached)* ____Other_____ *(proof attached)*

**Section D (Required only if Mental Health Information or Drug/Alcohol Abuse/Treatment Information is to be disclosed)**

_____ Date _____/_____/_____ Time_____:_____

**Signature of Witness to Signature (Preferably UPMC Hamot Staff Member)**

_____ Date _____/_____/_____ Time_____:_____

**Additional Witness Signature (Required only when patient is only able to make a mark)**