UPMC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE _____TO RELEASE INFORMATION FROM THE RECORD OF:
NAME OF FACILITY/DOCTOR

_____

PATIENT NAME **BIRTH DATE** **SSN/MR#**

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

100 Norman Drive Cranberry Twp., PA 16066
FACILITY/CONTACT 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:_____**(Enter the dates from the last year to the present. We require one year of medical records)**

   x Outpatient **x** Physician Office/Clinic

I authorize the release of: (check all that apply) ___Mental Health Information ___Drug and Alcohol Information contained records indicated above.

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

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)	

x Other:_____

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:_____**