PITTSBURGH MERCY
A HERITAGE OF HOPE

Please print and complete release then return to Pittsburgh Mercy

1200 Reedsdale Street, Pittsburgh PA 15233

Fax 412-320-2378 Phone: 412-320-2380

I hereby authorize Pittsburgh Mercy to Communicate and Exchange Information with**:**
(see bottom of form)

Consumer/Patient:	Medical Record Number:
Date of Birth:	SSN:

who was a consumer/patient at our/your facility, for the purpose of _____
(Reason for release)

Dates Requested: (From:_____/_____through)

TYPE OF INFORMATION TO BE DISCLOSED: ☐ INPATIENT ☐ OUTPATIENT

METHOD OF RELEASE (MUST CHECK ONE): *☐ VERBAL ONLY * ☐ COPIES ONLY * ☐ VERBAL & COPIES

**** Items for verbal sharing or for copies must be specifically checked below***

THE FOLLOWING INDICATED RECORDS OR INFORMATION IS BEING REQUESTED:

_____Include Substance Use Disorder _____Include HIV _____Include Mental Health _____Physical Health

Please indicate by check mark items requested:

Remember the five points for SUD consumers for gov't agencies and insurers

			Five Points
☐ Assessment	☐ Medications	☐ Psychological Testing Results	☐ Attending/Not Attending
☐ Behavioral Health Notes	☐ Discharge Summary	☐ Attendance Figures	☐ Diagnosis/Prognosis
☐ PMFHC Notes	☐ Lab Results	☐ Cummul. Academic Records	☐ Level/Nature of Treatment
☐ Physician Notes	☐ Physical Examination	☐ Teacher Observations	☐ Consumer Progress
☐ Psychiatric Evaluation	☐ Treatment Plan	☐ Clinical Summary	☐ Relapse/Frequency

☐ Other _____

ATTENTION OF:_____

_____
_____
_____
_____

(Name, Address, Program or Facility to which information is to be sent.)

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING INFORMATION THAT RELATES TO YOUR SIGNING THIS AUTHORIZATION TO USE/DISCLOSE. PLEASE INITIAL WHERE INDICATED.

I UNDERSTAND that I may revoke this authorization at any time by contacting the PMHS Health Information Management Department. My revocation must be in writing and will become effective upon PMHS having notice of it. I understand that PMHS will not be responsible for the use or disclosure of my health information to the extent that PMHS has relied on my authorization prior to its receipt of my revocation. If I have provided this authorization to obtain insurance coverage, I may not have the right to revoke the authorization to the extent that it pertains to the insurer's right under law to contest a claim under my insurance policy. **A verbal request to revoke this authorization shall be sufficient for information protected under the Substance Use Disorders regulations.**

I UNDERSTAND that this authorization is LIMITED to the PURPOSE and to the person listed above and will be **IN EFFECT FOR 90 DAYS** after the date of my signature, unless otherwise specified.

☐ This authorization will EXPIRE on the following date:_____ ***(Not to be longer than one year)***

I UNDERSTAND that information released by PMHS under this authorization might be re-disclosed by the receiving party, and therefore PMHS and its employees have no responsibility or liability as a result of any re-disclosure; as such, the released information is no longer protected by the Privacy Rule (HIPAA).
Any information that identifies any patient as a participant in any substance abuse treatment activities continues to be protected by federal and state law and regulation. Such information may not be re-disclosed by the recipient to anyone without the client's/patient's specific, informed, written consent.

I UNDERSTAND that information permitted to be released under HIPAA and the Privacy Rule is in fact prohibited by federal regulations (42CFR.Part 2) and state regulations (28 Pa. Code, Subsection 709.28) and so will not be released.

I UNDERSTAND that my request for this release of information may be restricted and is protected by state (Commonwealth of Pennsylvania regulations PA Mental Health Code, Chapter 5100, 4 Pa. Code Subsection 255.5(b)) and Federal Law. Federal Regulations (42 CFR.Part 2) prohibit the receiver of the information from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I UNDERSTAND that PMHS will not withhold treatment from me if I refuse to sign this Authorization for Use/Disclosure form.

I UNDERSTAND that I am entitled to a completed copy of this Authorization for Use/Disclosure form.

Please INITIAL to confirm you have read the above and fully understand the content.

Consumer/Patient initials_____

Consumer has been offered a copy of this release ☐Accepted ☐Declined

_____/_____ _____/_____
Witness (required for all authorizations) **Date** **Consumer/Patient (14 years of age or older, MH only)** **Date**

_____/_____ _____/_____
Witness (required for all authorizations) **Date** **Guardian/Legal Representative (for MH consumers only)** **Date**

ORAL CONSENT: For Persons Physically Unable to Provide a Signature. NOT applicable to HIV-Related Information. I witnessed that the person understood the nature of this release and freely gave his/her oral consent. (Two witnesses are required).

_____/_____ _____/_____
Signature of Witness #1 **Date** **Signature of Witness #2** **Date**