# AUTHORIZATION TO RELEASE HEALTH CARE RECORDS

| Patient's Name:<br>Address:<br><br>Date of Birth:<br>Social Security No: | I am, or have been, a patient with the below-referenced provider, or I am the patient's authorized representative. I understand that the provider has legally protected health information about me or the person whom I represent. I understand that signing or not signing this form will not affect treatment to be received in any way. |
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| Provider: | To be completed by claimant with the name and address of ANY and ALL physicians who have provided treatment. If none specifically listed, then to ANY Physician to be inserted. |
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I, the undersigned, hereby authorize __ANY__ health care provider or facility, physician or nurse who has attended to me, and/or any hospital at which I have been treated or confined, to furnish to UPMC Benefit Management Services, Inc., O'Brien, Rulis & Bochicchio, LLC, and/or to any of their representatives/designees, including but not limited to Litigations Solutions, Inc., any and all medical records and/or other available information concerning my physical or psychiatric condition/treatment rendered and, if necessary, to examine or copy any x-ray picture or other diagnostic films taken of me. Additionally, this Authorization allows for release of all billing information for treatment provided due to my alleged work injury if such information is specifically requested.

**Medical records are defined by state regulation as all "clinical information pertaining to the patient which has been accumulated by the physician, either by himself or through his agents." This includes any diagnostic test results, x-rays, physician notes, and any records from prior treating and/or consulting physicians.**

This request and authorization applies specifically to the dates of: ________ **to present.**
**(If dates of service are not specified, this Authorization shall apply to ALL dates of service)**
This request and authorization applies to the following records:

__X__ all hospital records (includes nurses records, progress notes, and copies of operative photos)
__X__ transcribed hospital records
__X__ medical records needed for continuity
__X__ most recent five-year history
__X__ laboratory reports
__X__ pathology reports
__X__ X-rays, MRIs, CT scans
__X__ diagnostic imaging reports
______ other (specify)______________________________
__X__ clinician office chart notes
__X__ dental records
__X__ physical therapy records
__X__ emergency and urgency care notes
______ billing statements
__X__ all reports

HIV, Behavioral Health as well as Drug and Alcohol information contained in the parts of the record(s) indicated above will be released through this authorization unless otherwise indicated. Do not release the follow records:
_____ HIV/AIDS Records _____ Behavioral Health (Psychiatric) Records _____ Drug and Alcohol Records

**I understand that the recipients of this information may re-disclose the information they are to receive as this information is being requested for the purpose of litigating and/or administering to a claim for workers' compensation benefits. The Provider has no responsibility or liability as a result of the re-disclosure, as such information would no longer be protected by the HIPPA privacy rule. While this Authorization is compliant with 45 C.F.R. 164.508 (HIPPA), it is provided as a courtesy to the provider, as the requirements of HIPPA do not apply to records requested with regard to workers' compensation matters.**

Attorney: Employer:__________________ Claim No:______________________

I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or Treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/ mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing and/or treatment as is outlined above.

________________________________________**(Signature of Patient)** ________________**(Date)**
**or Authorized Representative**

________________________________________ **Relationship/status if signed by anyone other than patient (i.e., parent, legal guardian, personal representative, etc.)**

***THIS AUTHORIZATION IS VALID FOR SIX (6) MONTHS FROM THE DATE SIGNED***

A COPY OR FACSIMILE OF THIS AUTHORIZATION SHALL BE CONSIDERED VALID AS AN ORIGINAL

THIS AUTHORIZATION IS REVOCABLE VIA WRITTEN REQUEST BY SIGNEE TO THE PROVIDER.