

UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC)
Authorization for Release of Protected Health Information

RELEASE OF PROTECTED HEALTH INFORMATION

- I authorize UPMC to provide information related to my care to be provided to the family/school/team physician, school nurse, coaches, athletic directors, school principals, EMS personnel, and such persons as needed for them to provide consultation, treatment, and establish a plan of care.
- I give authorization to UPMC to use my UPMC billing information for UPMC departmental internal reporting only.
- I give authorization to UPMC (including hospitals, other entities and programs) to access medical or other information maintained on electronic information systems or stored in various forms at individual UPMC affiliates related to treatment/or services provided to me by UPMC and/or any affiliate in connection with my care, health care operations, or payment for treatment and services. I also authorize information related to my care to be provided to my family/team/school physician and such persons as necessary for them to provide consultation, treatment, and/or services to me.
- I understand that my health record(s) will not be released or obtained by UPMC unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information (Authorization).
- I understand that the release of my health record(s) will be for the purpose stated on this form.
- I understand that the health record(s) released by UPMC may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) UPMC and its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- I understand that this Authorization is in effect for a period of the current scholastic sport season (fall, winter, or spring as designated by the school), or beyond in the event of the continued treatment of an injury from that designated sports season; however, not time frame specified shall go beyond one year from the date of signature.
- I understand that this Authorization is also in effect if I am treated for an injury during off-season workouts; however, no time frame specified shall go beyond one year from the date of signature.
- I understand that I have the right to revoke this Authorization form at any time by sending a written request to UPMC where the Authorization was provided.
- I understand that my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
- I understand that I am entitled to a copy of this completed Authorization form.

Athlete/Patient Signature	Date	UPMC Sports Medicine Representative
Parent/Guardian Signature	Date	UPMC Sports Medicine Representative
Signature/Identity on behalf of patient/relationship	Date	UPMC Sports Medicine Representative