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MEDICAL RECORDS/PROTECTED HEALTH INFORMATION (PHI) RELEASE

I, _____ _____ ,hereby authorize University Pain Medicine Center (UPMC), University Pain & Spine Center(UPSC), affiliated providers, and staff (collectively Referred to as, " Healthcare Providers") to :

- **Request and Receive my Protected Health Information (PHI):** I grant permission for the above-named medical practices, their physicians, staff, representatives, or designees to access, request, receive, and review copies of my PHI from any healthcare provider, physician, or facility.
  - **Definition of PHI:**
    Protected Health Information (PHI) includes any information about my health status, medical condition, treatment, or payment for healthcare services that can be linked to me as an individual. This includes but is not limited to, medical records, lab results, billing information, and other data that healthcare providers use to treat me or manage my care.
- **Hold Harmless Agreement:** I release and hold harmless the entity providing my PHI or medical records from any claims or damages resulting from the release of this information, should the requesting entity mismanage my PHI.
- **Notice of Privacy Practices:** I acknowledge that I may be provided with a copy of the above-named entities' Notice of Privacy Practices or PHI handling policies upon request.

Termination of Authorization: I understand and agree that this authorization shall remain in effect indefinitely and does not expire. However, I may revoke it at any time by providing a written request to any of the above-listed entities. Such revocation will not affect any actions taken before the receipt of the revocation.

By signing below, I confirm that I have read, understand, and agree to the terms stated above

_____ _____
Patient or Responsible Party Signature Date