# WEINSTEIN IMAGING ASSOCIATES, P.C.

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: ________________________________________ Date of Request :_______________________

Daytime phone: _____________________ Birthdate: ________________ Last 4 digits of Social Sec. #: ___________

Are records being mailed: Yes or No (circle one; if YES, please include a check for $5.00 to cover postage/handling fees, made payable to: Weinstein Imaging Associates)

or if being picked up, check here___ and list date of pick-up: _____________

Please note: If records are going to a UPMC facility, they will not need to be mailed or picked up, but will be transferred internally.

EXAM TYPE: Mammogram _____ Breast Sonogram _____ Other Sonogram _____ DXA _____ BSGI ______

I authorize Weinstein Imaging Associates to disclose or provide protected health information (PHI), about me, to the individual/entity listed below.

**Who will be authorized to receive information** (list the individual/entity that is to receive your PHI):

Individual/Entity: ______________________________________________

Address 1: ______________________________________________________

Address 2: ______________________________________________________

City/State/Zip: __________________________________________________

**Description of information to be disclosed** – I authorize Weinstein Imaging Associates to disclose the following protected health information about me to the individual/entity identified above (please check the specific information you want to be released):

○ Mammogram and/or breast sonogram images and/or reports Dates: _________________

○ Other sonogram images and/or reports Dates: _________________

○ DXA (bone density test) scans, reports, and/or disks Dates: _________________

**If this is a permanent transfer of your records, please initial here: __________**

**Purpose of disclosure** (please record the purpose of the disclosure or check patient request):

○ Patient Request ○ Other (please specify): ______________________________________________________

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: ______________
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice; this does not apply, however, to information already released. Also, this practice places no condition to sign this authorization on the delivery of healthcare/treatment.
- We have no control over the individual(s)/entity you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of this practice.
- If a CD/films are given to you personally, you must, by state law, maintain these records and make them available for medical and/or other purposes for a period of at least seven years. This responsibility is not relieved by transferring the CD/films to an individual or entity. Please note that CD/films are often lost if they are loaned to others.

_________________________________________ ___________________________

Signature of Patient or Personal Representative Date

You have a right to receive a copy of signed authorizations upon request.