WEINSTEIN IMAGING ASSOCIATES, P.C.
AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

PATIENT NAME: ______________________________________ Date of Request: __________________

BIRTHDATE: ______________________ DAYTIME PHONE #: ____________________________

PHI BEING REQUESTED: Mammogram ____ Breast Sonogram ____ Other Sonogram ____ DXA ____

X-Ray _____ Pathology/Biopsy Results _____ Follow-up Information/Recommendations ______

FACILITY THAT WE ARE REQUESTING PHI FROM: ____

1) I authorize ______________________________________ to release the above named individual's health information as specified below. **PERMANENT TRANSFER (initials): _________YES _________NO**

2) I authorize the following types and dates of health information to be used and/or released (initial):

- Mammogram CD/films and reports _____ Dates: ______________________
- Sonogram CD/films and/or reports _____ Dates: ______________________
- DXA scans, reports, and/or disks _____ Dates: ______________________
- X-Ray films and/or reports _____ Dates: ______________________
- Pathology results of recent surgery/biopsy _____
- Follow-up information and/or recommendations _____
- Entire medical record _____
- MRI _____

3) I authorize release of this information to Weinstein Imaging Associates, at the following location:

_____ 5850 Centre Avenue
Pittsburgh, PA 15206
Phone: 412.441.1161
Fax: 412.441.9880

_____ 1910 Cochran Road #740
Pittsburgh, PA 15220
Phone: 412.440.6999
Fax: 412.440.6998

_____ 5500 Corporate Drive
Pittsburgh, PA 15237
Phone: 412.630.2649
Fax: 412.630.2676

4) I understand that I have the right to revoke this authorization at any time, and that I must put that request in writing, and present that request to the HIPAA Compliance Officer or the Administrator of my facility who will deliver it to the Privacy Officer. I understand that this revocation will not apply to the information that has already been released, or to information that is required by law by my insurance company. This revocation will expire 6 months from today's date or earlier if I have specified here: Month: Day: Year:

6) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and my treatment will not be altered. I understand that I may see or copy the information to be used or disclosed.

______________________________ Signature of Individual or Legal Proxy

______________________________ Relationship to Individual

______________________________ Date

______________________________ Signature of Witness

______________________________ Date