

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

*For Office Use Only:*

PATIENT NAME: \_\_\_\_\_ Date of Request: \_\_\_\_\_  
BIRTHDATE: \_\_\_\_\_ DAYTIME PHONE #: \_\_\_\_\_ Date needed by: \_\_\_\_\_  
EXAM TYPE: Mammogram \_\_\_\_ Breast Sonogram \_\_\_\_ Other Sonogram \_\_\_\_ DXA \_\_\_\_ X-Ray \_\_\_\_  
CD/films to be picked up (enter date): \_\_\_\_\_ CD/films to be mailed out: \_\_\_\_\_ (\$5.00 fee applies)

***THIS PORTION TO BE FILLED OUT BY PATIENT OR LEGAL REPRESENTATIVE OF PATIENT:***

- 1) I authorize Weinstein Imaging Associates to release the above named individual's health information as specified below. **PERMANENT TRANSFER (initials):** \_\_\_\_\_ **YES** \_\_\_\_\_ **NO**
- 2) I authorize release of the following types and dates of health information (initial):
  - Mammogram and/or breast sonogram CD/films and/or reports \_\_\_\_\_ Dates: \_\_\_\_\_
  - Other sonogram CD/films and/or reports \_\_\_\_\_ Dates: \_\_\_\_\_
  - DXA (bone density test) scans, reports, and/or disks \_\_\_\_\_ Dates: \_\_\_\_\_
  - X-Ray films and/or reports \_\_\_\_\_ Dates: \_\_\_\_\_
  - Entire medical record \_\_\_\_\_
- 3) I authorize release of this information to the following physician, facility, or individual:  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_
- 4) I verbally authorized the faxing of my report to the physician/facility prior to the mailing or pick-up of my records. Date and time verbal authorization given: \_\_\_\_\_
- 5) I understand that if actual CD/films are sent or given to me personally, I must, by state law, maintain these records and make them available for medical and other purposes for a period of at least seven years. This responsibility is not relieved by transferring the CD/films to a physician or other institution. I am aware that CD/films are often lost if they are loaned to others.
- 6) 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 Weinstein Imaging Associates. I understand that this revocation will not apply to information that has already been released, or to information that is required by law by my insurance company. This revocation will expire in six months from today's date or earlier if I have specified here: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_
- 7) 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. I understand that once my information is disclosed, it may not be protected by the same high confidentiality standards as required by HIPAA and enforced by this facility. I understand that any questions I have concerning this can be answered by calling this facility's HIPAA Compliance Officer.

\_\_\_\_\_  
Signature of Individual or Legal Proxy

\_\_\_\_\_  
Relationship to Individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date