

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

*For Office Use Only:*

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: \_\_\_\_\_

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

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 \_\_\_\_\_

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