WEINSTEIN IMAGING ASSOCIATES, P.C.
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ Birthdate: ____/____/____ Date of Request :____/____/____

MRN #: _____ Requesting records from Weinstein Imaging (Office Location):___North Hills ___South Hills ___Bloomfield

Are records being mailed: ___Yes ___No
*If **YES**, choose an option below:
____Include a check ($5.00) to cover postage/handling fees, made payable to: Weinstein Imaging Associates (Check Received: ___/___/___)
____Call the office to pay the $5.00 over the phone via credit card (Credit Card Payment Received: ___/___/___)

*If **NO**, choose an option: _____CD – Held in office for pick-up Date of anticipated pick-up: ____/____/____
_____ CD – Mail ($5.00 fee as noted above)
_____PowerShare (UPMC or St. Clair Hospital only)
_____PowerShare (Other facilities; you MUST verify with facility if this option is available)

***Date of Appointment:** ____/____/____

RECORDS TO BE RELEASED: Mammogram _____ Breast Sonogram _____ Other Sonogram _____ DXA _____

I authorize Weinstein Imaging Associates to disclose or provide protected health information (PHI), about me, to the individual/entity listed below. **Individual/Entity/Facility that is to receive your PHI):**

Individual/Entity: _____ **Phone:** _____

Address 1: _____ **Fax:** _____

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 Date of Exam(s): ____/____/____
- ○ Other sonogram images and/or reports Date of Exam(s): ____/____/____
- ○ DXA (bone density test) scans, reports, and/or disks Date of Exam(s): ____/____/____

If this is a <u>permanent</u> 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.

_____ _____/_____/_____ (You have a right to receive a signed copy of this signed release)
Signature of Patient or Personal Representative **Date**

<u>For office use only</u>: **____/____/____Date Release Received ____/____/____Release Scanned ____/____/___ FilmTracking Done**

____/____/____Date 2nd Request Faxed ____/____/____Date PowerShare Completed/CD Mailed ____/____/____MRI Request Mailed

(Weinstein Imaging Associates 03/18/25)