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

To provide you with the best quality of care, we would like you to request your most recent mammogram/breast ultrasound or any other imaging pertinent to your upcoming appointment at our office. Please complete this form then fax/mail it to the prior facility listed below; preferably at least 2 weeks prior to your appointment to ensure they arrive in a timely manner. If the previous films are not available at the time of your appointment, your results may be delayed until the prior studies arrive. In some cases, you may need to reschedule your appointment at our office.

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

MRN #: _____ **(leave blank if unsure)** **PATIENT'S DAYTIME PHONE #:** _____-_____-_____

FACILITY TO RELEASE PHI: _____

FACILITY PHONE: _____-_____-_____ **FACILITY FAX #:** ____-____-_____

1) I authorize the above entity to release the following information to Weinstein Imaging Associates. I understand that I am giving permission for the above-named facility to disclose confidential health care records (PHI). I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the facility who is in possession of my records. Furthermore, I understand any revocation will not apply to the information that has already been released or to information that is required by law by my insurance company.

2) A copy of this consent shall be included in my original records. Weinstein Imaging may not re-disclose these records to anyone else without my separate written consent unless the recipient is a provider who makes disclosures permitted by law.

3) I authorize the following types and dates of health information to be released to Weinstein Imaging Associates:

- **Mammogram/Breast Ultrasound *(Powershare or CD/Reports)*** **Dates: Most recent 3 years _____**

- **Breast MRI (CD and reports) _____** **Dates: _____**
- **Other Ultrasound (CD and reports) _____** **Dates: _____**
- **Other MRI/CT (CD and reports) ____** **Dates: _____**
- **DXA (Reports only) _____** **Dates: _____**
- **X-Ray films and/or reports _____** **Dates: _____**
- **Pathology report of recent surgery/biopsy _____** **Dates: _____**
- **Consult/Follow-up information and/or recommendations _____** **Dates: _____**

4) 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

5) 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

For office use only: ____/____/____**Date Release Faxed/Mailed** ____/____/____**Date of 2nd Request** ____/____/____ **Date of 3rd Request**

____/____/____**Release Scanned** _____/_____/_____**Date of Patient Appointment** _____/_____/_____**Records Received**