

Name of Practice:	Western PA Women's Healthcare Associates Drs. Krupski, Ichikawa, Noh, Woo, Lareau & Carroll	
Address:	850 Clairton Blvd, Suite 3100, Pittsburgh, PA 15236	
Privacy Official:	Pearl Montgomery	
Telephone:	412-466-2115	Fax 412-466-4668

**Authorization for Use or Disclosure
of Health Information**

Patient Name: _____
[print or type]

Patient's Date of Birth: _____ Patient's Social Security Number: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

Specific Description of the Information to be Used or Disclosed Including (If Practicable) the Dates of Service(s) Related to Such Information:

Mammogram/No Films/Hard Copy Only _____ Date of Mammogram _____

The above information will be called "Authorized Information" throughout the rest of the form.

Persons or Class of Persons Authorized to Release the Authorized Information:

Persons or Class of Persons to Receive the Information:

Authorized Information will be used and/or disclosed for the following purposes:

- At the request of the individual (check box if applicable)
- Other (*Please list each purpose of the use(s) or disclosure(s) in the space provided.*):

- I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying Western PA Women’s Healthcare Associates in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Western PA Women’s Healthcare Associates before receiving my revocation, or to information that is required by law by my insurance company.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits

[ALTERNATIVELY, IF APPLICABLE: I understand that Western PA Women’s Healthcare Associates may require me to sign an authorization prior to receiving research-related treatment or treatment solely for the purpose of creating health information for another party and that Western PA Women’s Healthcare Associates will not provide such research-related treatment unless I provide this authorization. **NOTE:** If this provision is applicable, the third party for whom the information is being created must be listed under “Persons or Class of Persons to Whom the Use or Disclosure of Authorized Information May be Made.” Also, the purpose for which the information is to be created and disclosed must be listed under “Authorized Information will be Used or Disclosed for the Following Purposes.”

- [FOR MARKETING AUTHORIZATIONS ONLY, IF APPLICABLE] I understand that the person or entity I am authorizing to use and/or disclose Authorized Information for marketing purposes may receive either direct or indirect compensation for doing so.

This authorization expires at the earlier of 6 months **OR the date the following event occurs:** _____
 [describe event or write “not applicable”]

Signature of Patient or Patient’s Personal Representative: _____
Date: _____

For Personal Requirements of the Patient (if applicable):

Print Name of Personal Representative: _____

Describe Personal Representative Relationship/Authority to Act for the Individual (parent, guardian, etc.): _____