

<b>Name of Practice:</b>	<b>Western PA Women's Healthcare Associates Drs. Krupski, Ichikawa, Noh, Woo, Lareau &amp; Carroll</b>	
<b>Address:</b>	<b>300 Halket Street, Suite 5730, Pittsburgh, PA 15213</b>	
<b>Privacy Official:</b>	<b>Pearl Montgomery</b>	
<b>Telephone:</b>	<b>412-641-6223</b>	<b>Fax 412-641-6227</b>

**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.*):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

