AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

*For use by **Western Pathology Associates Ltd and Pinnacle Pathology PC "WPA/PP"** clients/patients*

Note: Forms CANNOT be submitted electronically. Forms must be printed and completed. Completed forms may be submitted via regular mail or fax to:

Western Pathology Associates Ltd
Pinnacle Pathology PC
HIPAA Privacy Officer
9250 N 3rd Street #4000
Phoenix, AZ 85020
Phone: (602)633-3800
Fax: (602)861-3500

Patient Name:	Account/Patient ID:
Entity:	Date of Birth:
Phone:	Client Name:

I authorize the Entity above to release health information to:

_____
Name of person or facility to receive health information

_____
Specify name/title of person to receive health information, if known

_____
Street Address, City, State, Zip Code

INFORMATION TO BE RELEASED:

Dates of Service: _____ ☐ Pathology Reports ☐ Pathology Paraffin Blocks ☐ Pathology Slides ☐ Other: _____	Dates of Service: _____ ☐ Pathology Reports ☐ Pathology Paraffin Blocks ☐ Pathology Slides ☐ Other: _____

THE PURPOSE OF THIS RELEASE IS:

☐ At the request of the patient/patient representative
☐ Other (state reason): _____

Patient/Patient Representative Initials _____

YOUR RIGHTS & ACKNOWLEDGEMENTS:

- WPA/PP and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected under federal or state confidentiality laws.
- I understand this authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to the Privacy Officer of WPA/PP at the correspondence address. The revocation will take effect when WPA/PP receives it, except to the extent that WPA/PP have already relied on it.
- I am entitled to receive a copy of this Authorization.
- I further understand that WPA/PP may impose a reasonable cost-based fee for preparing a summary of the Protected Health Information if the parties agreed to such summary and fees in advance.
- Unless otherwise revoked in writing, this Authorization expires _____(insert applicable date or event). If no date is indicated, this Authorization will expire in 12 months after the date of signing this form.

SIGNATURE

Client/Patient: _____ Date signed: _____

If applicable:
Signature – Personal/Legal Representative of Client/Patient: _____

Relationship to Client/Patient: _____ Date signed: _____

Witness (only if patient unable to sign) or Interpreter: _____

Internal Use Only - Date received in Privacy Management Office: _____ *Ref No:* _____