LOREN S. FUNT, M.D.
SUSAN L. SAFYAN, M.D.
JASON G. WHALEN, M.D.
GRETCHEN M. KREIZENBECK, M.D.
NICOLE E. FUNT, MPAS, PA-C

MT. LEBANON DERMATOLOGY, PC

607 WASHINGTON ROAD
LOWER LEVEL
MT. LEBANON, PA 15228
TELEPHONE: (412) 440-0270 FAX: (412) 440-0271

PATIENT NAME: Pat Whole Name (Last Name First) DOB: Pat DOB

1. I authorize the use or disclosure of the above named individual's health information described below. (Please use an X or a check mark to make your choices) (Please print all information)

2. The following entity is requested to release Information:
 X Mt. Lebanon Dermatology, PC
 ______ Other (please specify) ______
 ______ Fax Number ______

3. Who will be authorized to receive Information (list the person/entity who is to receive your PHI):
 N/A Mt. Lebanon Dermatology, PC
 ______ Name: ______
 Address: ______
 ______
 ______ Fax Number: ______

4. Description of the information to be disclosed: (Please check the items to be disclosed)
 ______ Progress Note(s) ______ All ______ Date(s) ______
 ______ Biopsy Report(s) ______ All ______ Date(s) ______
 ______ Lab and or X-Ray Report(s) ______ All ______ Date(s) ______
 ______ Only send the following ______
 ______ Financial history report (previous 3 years only)
 ______ Record of HIV and communicable disease testing
 ______ Record of mental health or substance abuse treatment
 ______ Complete Medical record
 ______ Only send the following: ______

5. Purpose of the disclosure: (please record the purpose of the disclosure or check the patient request)
 ______ Patient request ______ To evaluate my eligibility for life insurance.
 ______ At the request of my attorney ______ To evaluate my eligibility for disability benefits.
 ______ Other ______

* Right not to sign: You may refuse to sign this authorization (The practice places no condition to sign this authorization on the delivery of healthcare or treatment). Refusal to sign will not affect your ability to obtain treatment by Mt. Lebanon Dermatology, PC, except when health services are solely for the purpose of reporting to a third party such as a school physical.
* Right to Revoke: You may revoke this authorization at any time. Your revocation will not apply to any release we have already made in response to this authorization. To revoke this authorization, you must submit a written revocation to our privacy officer at the following address: 660 Washington Road, Suite 201, Pittsburgh, PA 15228.
* Redisclosure: I understand that once the information listed above has been disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
* Right to a Copy: I understand that I have the right to have a copy of this authorization to release my medical information to the above stated entity upon request.
* Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition: ______ (If I do not specify an expiration date, event or condition, this authorization will expire in 12 months from the document date.)

Patient/personal representative signature ______ Date: ___/___/___
Personal Rep. Information (as applicable): Name/relationship: ______