MT. LEBANON DERMATOLOGY ASSOCIATES, PC

607 WASHINGTON ROAD
LOWER LEVEL
MT. LEBANON, PA 15228

TELEPHONE: (412) 563-0217
FAX: (412) 668-0606

PATIENT NAME: _____ 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:
   _____Mt. Lebanon Dermatology Associates, PC
   ___X___Other (please specify)_____
   _____Fax Number_____

3. Who will be authorized to receive Information (list the person/entity who is to receive your PHI):
   ___X___**Mt. Lebanon Dermatology Associates, PC**
   _____Name:**Mt. Lebanon Dermatology Associates, PC**
   Address:**607 WASHINGTON ROAD, LOWER LEVEL, PITTSBURGH, PA 15228**
   ___X___Fax Number:**412-668-0606**

4. Description of the information to be disclosed: (Please check the items to be disclosed)
   ___X___Progress Note(s) ___X___All _____Date(s)_____
   ___X___Biopsy Report(s) ___X___All _____Date(s)_____
   ___X___Lab and or X-Ray Report(s) ___X___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.
   ___X___Other: **CONTINUATION OF CARE**

* **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 Associates, 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: 607 Washington Road, Lower Level, Pittsburgh, PA 15228.

* **Redisclosure:** I understand that once the information listed above has been disclosed, it may be re-disclosed 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:**_____