

WHALEN DERMATOLOGY OF PITTSBURGH

160 MILLERS RUN ROAD, SUITE 500
BRIDGEVILLE, PA 15017
TELEPHONE: (412) 564-5444
FAX: (412) 564-5478

WEBSITE: WWW.WHALENDERM.COM

PATIENT NAME: _____ **DOB:** _____

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

2. The following entity is requested to release Information:

_____ WHALEN DERMATOLOGY OF PITTSBURGH
_____ Other (please specify) _____
_____ Fax Number _____

3. Who will be authorized to receive Information (list the person/entity who is to receive your PHI):

_____ WHALEN DERMATOLOGY OF PITTSBURGH
_____ 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 Whalen Dermatology of Pittsburgh 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: 160 Millers Run Road Suite 500, Bridgeville, PA 15017.

* 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: _____