Goldstein
Medical and Aesthetic Dermatology

67 Union Street, Suite 501
Natick, MA 01760

Jay A. Goldstein, MD
Courtney Nascimento, FNP
Karlee Walther, FNP

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Jay A. Goldstein, M.D.
67 Union Street Suite 501
Natick, MA 01760
Phone 508-655-0525 / Fax 508-647-0960

Please complete this form thoroughly. Your medical records cannot be released until this form is completed and signed by the patient or legal guardian. A photo I.D. is required to confirm patient identity.

TODAYS DATE: ____

STEP 1: INFORMATION ABOUT YOU:

Patient Name: ____
Date of Birth: ____
Address: ____
Street City State Zip
Phone Number: Alternate Phone:____

STEP 2: TO WHOM DO YOU WISH TO RELEASE YOUR RECORDS? PLEASE PRINT

I authorize release of all of the following information unless specifically checked below:

_____Complete Health Records _____Laboratory Reports_____Pathology Reports _____Progress Notes Only

______Consultation Reports _____Other_________________

Dates of Treatment: ___________________________________ to ____
Release to: Name: ____
Address:____
Phone #: ____ Fax #____

STEP 3: YOUR SIGNATURE

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for re-disclosure beyond stated time is required.

____
Patient's Signature

____ ____
Witness Signature Parent/Guardian's Signature

STEP 4: RELEASE FOR SENSITIVE INFORMATION:

I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.

____ Date __________________________________

Signature of Patient or Legal Guardian

Printed Name ____

STEP 5: RELEASE OF HIV INFORMATION:

IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW.

I AGREE TO THE RELEASE OF THIS INFORMATION:

____ Date __________________________________

Signature of Patient or Legal Guardian

Printed Name ____

For Internal Use: _ Faxed _ Mailed By Whom: _____________I.D. Verified_____________________________