Medical Records Release Form

(Release from Scarsdale Medical Group)

To request release of medical/health information, please complete and sign this form and return it to:

Scarsdale Medical Group, LLP
Health Information Department, Suite 301
600 Mamaroneck Avenue, Harrison NY 10528
Fax: 914-219-1933
Email: healthinformation@scarsdalemedical.com

If you need help completing this form, Please contact our Health Information Department at (914)723-8100, Ext. 158

Patient Information:

Last Name _____ First Name _____ Date of Birth____/____/_____
Street Address_____ City_____
State _____ Zip_____ Telephone_____

Information Requested: (please be specific and enter dates of service, if known)

Progress notes from SMG and from Central Westchester Dermatology (scanned); any pathology/laboratory — blood and cultures ordered by Dr. Jennifer Goldwasser; photos by Dr. Goldwasser; dermatology communications and emails; consultation letters to Dr. Goldwasser

Restrictions and Exclusions: ☐ ***Psychiatric*** ☐ ***HIV/Aids Testing*** ☐ ***STD Testing***

Medical Records are released to the following:

Doctor Dr. Jennifer Goldwasser Practice Name Hudson Dermatology
Street Address 155 White Plains Rd., Suite 109
City Tarrytown State NY Zip 10591
Telephone Number (914) 829-8200 Fax Number (914) 829-8201

Reason for requested Information disclosure:

☐ Transfer of health coverage ☐ Personal Use ☐ Form Completion ☐ Referral ☒ Change of healthcare provider

*** If your request is for purpose of personal use (self), please be aware there will be flat rate of no greater than $25.00 plus shipping and handling when applicable***
All requests less than 20 pages will be free of charge
CHECK MUST BE PAYABLE TO: "DATAFILE"

I hereby authorize Scarsdale Medical Group to release any medical information as requested above. This may include information about drug and/or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date. I can, however, revoke this authorization at any time, except to the extent that Scarsdale Medical Group has acted upon it. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer be protected by federal law.

I understand that the Scarsdale Medical Group will continue to provide care, even if I do not authorize this release.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian (if minor) Date

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS.
This release is intended to comply with the Health Information Portability and Accountability Act (HIPAA).