Medical Records Release Form for Continuity of Care
(records to be sent electronically to Jennifer Goldwasser, MD and/or to patient, as indicated)

Please complete, sign, and send this form to your physician or medical group.

Patient Information (please print):

Name: _____

Date of birth: _____

Address:

_____

_____

_____

Phone: _____

REASON FOR REQUEST: CONTINUITY OF CARE

Information Requested:

- **All progress notes written by Jennifer Goldwasser**
- **All documents and plans from within a Jennifer Goldwasser Encounter/Visit**
- **All photographs taken during a Jennifer Goldwasser Encounter/visit**
- **Billing tickets –associated with a Jennifer Goldwasser Encounter/Visit**
- **All pathology reports specific to Jennifer Goldwasser or Dermatology**
- **Labwork results ordered/assigned under Jennifer Goldwasser**
- **Medications ordered under Jennifer Goldwasser**
- **Consult letters from outside doctors addressed to Jennifer Goldwasser**
- **Records from outside providers sent to Jennifer Goldwasser**
- **Patient Communications (phone calls, faxes, emails) from/to Jennifer Goldwasser**
- **Old dermatology progress notes from 'Hospital Reports' category section Nextgen)**

Medical Records are to be released to:

□ Dr. Jennifer Goldwasser at this HISP address: jgoldwasser@goldwasser.emadirect.md

□ Please send my records to me via secure email--email address: _____

I hereby authorize you,

_____ Scarsdale Medical Group/White Plains Hospital

_____ Hudson Dermatology

_____ Other (please specify): _____

to release all medical information requested above. This may include protected information. This authorization will expire 10 years from the signature date. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer be protected by federal law.

_____ _____

Signature of Patient (or parent/legal guardian, if patient is a minor)

_____

Date