Upstate
DERMATOLOGY
MEDICAL & SURGICAL SKIN CARE

Medical Practice of A. Neal Gregory, MD, MPH

Authorization to Release Protected Health Information

Patient's Name: _____

Phone Number: _____ Date of Birth: _____

I hereby authorize _____
to release protected health information of the patient named above and request that a copy of this information be

☐ Provided to me in person when I appear in person
☐ Mailed to the following person at the following address:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

☐ Electronically transmitted to the following address: _____

Release Information from:
☐ 1770 Route 9, Ste 202 Clifton Park, NY 12065 (P: 518-631-2933, F: 518-371-7102)
☐ 1547 Columbia Tpke, Castleton, NY 12033 (P: 518-479-4156, F: 518-479-3794)
☐ 113 Hudson Ave, Chatham, NY 12037 (P: 518-392-6742, F: 518-392-6019)
☐ 461 Clinton St. Ext., Schenectady, NY 12305 (P: 518-374-7222, F: 518-374-2051)

Dates of Records:
From _____
To _____

Information to be released: (Check and initial all that apply)

_____ ☐ Progress Notes _____ ☐ Pathology _____ ☐ Copies of Photos

_____ ☐ Misc. Reports _____☐ Surgery Notes _____ ☐ Consult Notes

_____ ☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient: _____ Date Signed: _____
(Signature of Patient or Representative Authorized by Law)

Released by (employee name): _____ Date Signed: _____

The practice reserves the right to charge for copying protected health information.