



**PATIENT CONSENT
RELEASE OF SLSS CONFIDENTIAL INFORMATION**

I, _____, do hereby request and authorize

David J. Goldberg, M.D. and staff of Skin Laser & Surgery Specialists of NY/NJ located in Hillsborough/Hackensack/New York **to release** information in my clinical records

dated from _____ to _____ for the following

purpose _____

to _____

(name and address)

The information to be disclosed shall be limited to that information necessary to fulfill the necessary level of care and may include the following items (**unless crossed out by me**)

Drug and/or Alcohol Abuse Information

Diagnosis of AIDS

History/Physical Examinations

Consultations

Diagnostic Testing

Psychosocial History

Information regarding HIV, including laboratory test results

Other _____

I understand that this consent may be revoked by me at any time except to the extent that Skin Laser & Surgery Specialists of NY/NJ has already acted in reliance on this consent. If not revoked by me, in writing, this consent will terminate upon:

(state specific date, even, or condition)

Date _____ Signature of patient _____

Signature of parent/guardian (when required) _____

Signature of person authorized to sign in lieu of patient (when required)