David M.Vernick, MD, FACS Harsha V. Gopal, MD E. Ashlie Darr, MD

AUTHORIZATION FOR THE RELEASE OF PROTECTED OR PRIVILEGED INFORMATION

I hereby authorize:
Vernick and Gopal, LLC
1244 Boylston Street, Suite 303
Chestnut Hill, MA 02467
Tel. 617-383-6800
Fax. 617-383-6801

or their agents to use and disclose my individually identifiable health information including the release of a copy of my medical record or a specified portion thereof to:

Name: _____

Location: _____

Purpose of release (circle below):

Medical Care Insurance Legal Matter Personal Other _____

I authorize this use, disclosure, and release with the understanding that it may include specifically protected or privileged information in one or more of the following categories: a) information relating to alcohol or drug abuse; b) communications between the patient and a social worker; c) information related to sexually transmitted diseases; d) communications between the patient and a psychotherapist (including psychiatrists, licensed psychologists, and psychiatric clinical nurse specialists); e) genetic test results (excludes therapeutic genetic tests); f) domestic violence victim's counseling; g) sexual assault counseling.

I HAVE PLACED A LINE THROUGH AND INITIALED ANY PORTION OF THE PARAGRAPH ABOVE THAT LISTS INFORMATION WHICH I DO NOT WANT RELEASED.

I understand that the information I authorize an individual organization to receive may be re-disclosed and no longer protected by federal privacy regulations. I understand that I may inspect or copy the information used and disclosed. I know that I may revoke this authorization at any time by notifying the above named organization in writing, provided the information has not already been disclosed. I know that this authorization is voluntary. I understand that treatment will not be conditioned on the completion of this authorization. I know that I have the right to request and receive a Beth Israel Deaconess Medical Center Notice of Privacy Practices.

Name of Patient: _____

Date of Birth: _____ MRN: _____

Patient Address: _____

Please circle information to be released below: from ____/____/____ through ____/____/____

Visit Notes Laboratory Reports Entire Patient Medical Record

X-rays/X-ray Reports (please specify) _____ Other _____

This authorization expires in (please circle): 3 months 6 months other ____/____/____

(If not specified, all authorizations will expire 12 months from the date this form was signed)

_____ Date: ____/____/____
Signature of patient or patient representative

_____
Print name and relationship if other than patient

Rev. 10/16/14