Theodore A. Golden, M.D.

I practiced Dermatology for 39 years at 40600 Van Dyke, Sterling Heights, MI. The site is now a used car parking lot. I deeply appreciate the opportunity and trust that you gave and placed in me to treat you for your Dermatology problems. I gained a great deal of satisfaction and joy knowing that I was able to help most of you. It pained me when I did not see a good outcome.

I went to the University of Michigan for both undergrad and Medical School. I am deeply grateful to the late Dr. Clarence S. Livingood, the Chief of Dermatology at Henry Ford Hospital, for choosing me to be one of his Dermatology residents. Dr. Livingood was a superb mentor and teacher of Dermatology. Everyday I always tried to practice Dermatology the way that my Chief, Dr. Livingood, taught me.

I served two years in the Navy with the Marines at Camp Lejeune, NC, as the Chief of Dermatology at the Naval Hospital. In 1974 after leaving the Navy I opened my solo practice of Dermatology at 40600 Van Dyke. I was an original at Troy Beaumont when it opened in 1977. I served as the Chief of Dermatology at Troy Beaumont for over twenty years.

And now for some specifics about procedures following my closing

Refills

Refills are no longer available because my office has been closed for over one year.

Medical Records

Medical records will be stored for a period of seven years after the date of your last visit. They are stored under my care at 181 Shagbark Dr., Rochester Hills, MI 48309. Medical records may be obtained by printing out the included form at the end of this publication as two separate pages in order to facilitate its printing. The instructions on the form must be followed completely in order for records to be released.

Referrals to other Dermatologists

I have contacted the Wayne State University Physicians Group-Dermatology.

WSUPG Dermatology
1560 E Maple Rd Ste 200
Troy, MI 48083-1138
Telephone:248-581-5200

A board certified dermatologist in that group will be happy to see you.

Again, I want to thank all of you for choosing and allowing me to be your Dermatologist.

Best wishes,

Theodore A. P. Golden, M.D.

Authorization for the Use or Disclosure of Your Health Information

(Note: This form is the only form that can be used to obtain your medical records.)

By signing below, I hereby authorize Theodore A.P. Golden, M.D. to disclose or release all of my Protected Health Information or a copy of such to:

Name:

Address:

(or) Fax No.:

The purpose of disclosing my Protected Medical Information to the above is because Dr. Golden has discontinued his practice.

The specific person or class of persons who are authorized to release or disclose all of my Protected Health Information or a copy of all my Protected Health Information to the above is Theodore A.P. Golden, M.D.

This Authorization shall expire after my medical records are released one time.

This form must be mailed to Dr. Golden at:

Theodore A. Golden, M.D.

181 Shagbark Dr.

Rochester Hills, MI 48309

I understand that Dr. Golden is entitled to charge a reasonable fee to release my records. The fee is $10.00 payable in advance by check to Theodore A. Golden, M.D. before my records can be released. I also understand that I will have to provide a stamped self addressed envelope if I want to receive physical copies and not faxed copies. I must supply a fax number if the copies are to be received by fax. The copies will be delivered by either mail or fax and not by both means, and I must specify the mode of delivery. I have the right to revoke this Authorization, if the revocation is in writing and received by Dr. Golden prior to the Authorization being executed.

I understand that my Protected Health Information that is used or disclosed pursuant to this Authorization may be subject to redisclosure by the person(s) you have disclosed it to.

I acknowledge that I have read and understand this Authorization. I authorize the use of disclosure of my Protected Health Information in accordance with the terms of this Authorization. I have enclosed a check for $10.00 payable to Theodore A. Golden, M.D., and a stamped self addressed envelope if I wish to receive physical copies.

Patient's Name Printed _____

_____ _____

Patient or Authorized Representative Signature Date Signed

_____ _____

Patient's Date of Birth Patient's Address

Delivery Mode: (Circle Only One)

Mail and Self Addressed Stamped Envelope Enclosed

or

Fax and Number is_____

_____

Witness