DALE R. TRAFICANTE, M.D., F.A.C.S.
UROLOGY
Board Certified Urologist

Authorization for Disclosure of Medical Record Information

Patient's Name _____ Date of Birth _____SS#_____

Address _____

I, the undersigned hereby authorize and request the release of my medical records to:

Dale R. Traficante, MD

I understand and acknowledge that certain information which may be contained in the medical record requires specific authorization for disclosure and except as otherwise provided by law, such information may not be disclosed without my specific consent. Additionally, I have the right to refuse disclosure and prevent any other person from disclosing such information. Such information includes information pertaining to (I) treatment for mental or emotional conditions, (II) alcohol/drug abuse or (III) HIV testing or test results.

Information to be released/disclosed (check all that apply):

☐ Entire Medical Record (including if any, mental health information, substance abuse information HIV testing information and results.

☐ Laboratory Results

☐ Dr. Notes

☐ HIV Testing information and results

☐ Progress Notes

☐ Diagnostic Studies

☐ OP Notes

☐ Other

I do hereby agree to release, indemnify and hold harmless, Dale R. Traficante, M.D., P.A., its directors and employees from and against any claims or liability by it or any item, arising out of or in connection with the disclosure of medical information authorized by me pursuant to this consent.

THIS CONSENT AND AUTHORIZATION SHALL AUTOMATICALLY EXPIRE 90 DAYS FROM THE DATE OF THIS CONSENT, UNLESS REVOKED BY THE PATIENT OR THE PATIENT'S REPRESENTATIVE PRIOR TO THAT TIME.

_____ _____

(Signature of Patient or Authorized Representative) (Print Name)

_____

(Relationship to patient)

(For Release Use Only) Released by: _____ Date: _____