AUTHORIZATION TO DISCLOSE PATIENT INFORMATION

I, (NAME)_____ born _____, Hereby consent to allow **Aldo Trovato, M.D., P.C.** to disclose information contained in, provide access to, or provide such photocopies as may be requested of my medical/billing information to the person or organization listed below :

The information from my records may be released to :

PERSON(S): _____ COMPANY_____

ADDRESS : _____

CITY/STATE/ZIP: _____

The purpose or need for this release of information is :

_____

The specific information to be disclosed is :

_____ Entire Chart _____ Laboratory Notes Dates of Service: _____ to _____

_____ Progress Notes _____ Pathology Reports

I hereby release **Aldo Trovato, M.D., P.C.** and its staff from all legal responsibility or liability which may arise from the release of or reproduction of such medical/billing information to the recipient.

I understand that this consent is subject to written revocation by me at any time except in those circumstances in which **Aldo Trovato, M.D., P.C.** or its staff has taken action in reliance of it. Without such written express revocation, this consent will expire 180 days from the date I sign this authorization, whichever is sooner.

I understand that **Aldo Trovato, M.D., P.C.** is entitled to request and receive reasonable fees for providing such photocopies of my medical record(s) as may be requested as a condition precedent to their release.

Authorization must be signed by the patient. If the patient is a minor or is an incompetent adult, authorization must be signed by their guardian. If there is no guardian appointed by the Court, the authorization must be signed by the nearest relative. If the patient is unable to sign this authorization, please state the reason : _____

_____

THIS CONSENT AND AUTHORIZATION MAY INCLUDE, BUT IS NOT LIMITED TO THE RELEASE OF PSYCHOLOGICAL, PSYCHIATRIC, ALCOHOL, DRUG ABUSE AND HIV/AIDS INFORMATION.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE SIGNED

_____

RELATIONSHIP (IF OTHER THAN PATIENT)

_____

ADDRESS

_____ (_____)_____

CITY, STATE, ZIP CODE TELEPHONE

_____ _____

WITNESS DATE SIGNED

9/6/2017