SCOTT D. DUDAK, MD, FACS
Urology and Urologic Surgery

9325 Glades Road, Suite 101
Boca Raton, FL 33434
Phone (561) 482-8111
Fax (561) 451-1768

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Patient's Name: _____ DOB: _____ /_____ /_____

Previous Name: _____ SSN: _____-_____-_____

I REQUEST AND AUTHORIZE: (Physician's Name) _____
to release healthcare information of the patient named above to:

Scott D. Dudak, MD
9325 Glades Road, Suite 101
Boca Raton, FL 33434
Phone: (561) 482-8111
Fax: (561) 451-1768

THE PURPOSE OF THIS AUTHORIZATION IS:

- ☐ Transfer of care
- ☐ To Assist with diagnosis or treatment
- ☐ Process insurance application
- ☐ Process insurance/disability claims
- ☐ Notes
- ☐ Labs
- ☐ Operative notes
- ☐ X-ray reports
- ☐ Legal (please specify) _____
- ☐ Other (please specify) _____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. I understand that this authorization is valid until it expires one year from the date written below, unless revoked before that. I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information.

_____ /_____ /_____	_____	_____
Date	Patient, please PRINT name above	Patient Signature Above
_____ /_____ /_____	_____	_____
Date	Witness, please PRINT name above	Witness Signature Above