CENTRASOTA ORAL SURGEONS

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:_____ Social Sec#_____

Address:_____

City, State, ZIP:_____

Birth Date:_____

THIS WILL AUTHORIZE CENTRASOTA ORAL SURGEONS TO REQUEST INFORMATION FROM:

[MEDICAL CLINIC NAME(S)] *Please include all primary care and specialty clinics*

The following information is to be released/reviewed:

_X_ History and Physical Exam

_X_ CBC/INR lab results from past 6 months

Other:_____

_X_ Medication and Diagnosis List

_X_ Clinic Notes

I am requesting this information be released for the following purposes:

_X_ Continued care by another provider ___ Insurance claim purposes ___ Other _____

- With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will not be released unless otherwise indicated by initialing: _____
- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire six months from the date of my signature, or a lesser period of time as specified here: _____
- I understand that once information is released pursuant to this authorization, we cannot prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid.
- Fax or copy is valid as original.

_____ _____

SIGNATURE OF PATIENT/AUTHORIZED PERSON DATE
(If authorized person is signing, please also print name)

REASON PATIENT IS UNABLE TO SIGN: ___MINOR ___INCOMPETENT ___DISABLED ___DECEASED