MINNESOTA ORAL AND FACIAL SURGERY
EXCELLENCE IN SURGICAL CARE
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AUTHORIZATION TO RELEASE PROTECTED HEALTH. INFORMATION

Patient Name: _____ Birthdate: _____
Address: _____ Social Sec#: _____
City, State, zip: _____ Patient Phone # _____

PATIENT MUST COMPLETE CLINIC NAME, DOCTOR NAME AND CLINIC PHONE NUMBER

Medical Clinic Name _____

Medical Doctor Name _____

Medical Clinic Phone Number _____

THIS WILL AUTHORIZE CENTRAL LAKES ORAL & FACIAL SURGERY TO REQUEST INFORMATION

The following Information is to be released/revlewed: **NURSE'S USE ONLY**

_ History 3 Physical Exam _ Discharge Summary _ Operative Reports _ Emergency Dept Reports
_ Hospital Outpt Reports _ Laboratory Reports _ Pathology Reports _ III-Ray Reports
_ Films _EKG/Echo Reports _Consultation Reports :_ Clinic Notes _ Medication & Diagnosis List

I am requesting this Information be released for the following purpose:

AUTHORIZATION TO RELEASE PROTECTED HEALTH. INFORMATION
_ **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.**

_____
DATE:

_____
SIGNATURE OF PATIENT/AUTHORIZED PERSON:
(if authorized person is signing, please also print name)

REASON PATIENT IS UNABLE TO SIGN: _ MINOR _ INCOMPETENT _ DISABLED _ DECEASED
****PHOTOCOPIES OF THE AUTHORIZATION MAY BE ACCEPTED IN LIEU OF THE ORIGINAL****