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 MINNESOTA ORAL & FACIAL SURGERY TO REQUEST INFORMATION

The following information is to be released/reviewed: NURSE'S USE ONLY

___ History & Physical Exam ___ Discharge Summary ___ Operative Reports ___ Emergency Dept Reports

___ Hospital Outpt Reports ___ Laboratory Reports ___ Pathology Reports ___ X-Ray Reports

___ Films ___EKG/Echo Reports ___Consultation Reports ___ Clinic Notes ___ Medication & Diagnosis List

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

___ 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 can not 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******