CENTRASOTA ORAL SURGEONS

3950 VETERANS DRIVE	510 22ND AVENUE EAST
SUITE 100	SUITE 103
ST CLOUD, MN 56303	ALEXANDRIA, MN 56308
PHONE: 320-252-3611	PHONE: 320-763-5117
FAX: 320-252-7574	FAX: 320-763-5118

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:____

Address:____

City, State, ZIP:____________________________________

Birth Date:________________________

THIS WILL AUTHORIZE CENTRASOTA ORAL SURGEONS TO REQUEST INFORMATION FROM:

____

(CLINIC NAME AND/OR DOCTOR'S NAME)

The following information is to be released/reviewed:

___ History and Physical Exam	___ Discharge Summary	___ Operative Reports
___ Emergency Dept Reports	___ Hospital Out-pt Reports	___ Laboratory Reports
___ Pathology Reports	___ X-ray Reports	___ Films
___ EKG/Echo Reports	___ Consultation Reports	___ Clinic Notes
___ Medication and Diagnosis List		

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

___ 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