CENTRASOTA ORAL SURGEONS

3950 VETERANS DRIVE	2633 JEFFERSON STREET
SUITE 100	SUITE 602
ST CLOUD, MN 56303	ALEXANDRIA MN 56308
PHONE: 320-257-8241	PHONE 320-763-5117
FAX: 320-257-8243	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 Outpt 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

04-09-21