CENTRASOTA ORAL SURGEONS
3950 Veterans Drive, Suite#100
St. Cloud, MN 56303
PHONE: 320-257-8241
FAX: 320-257-8243
EMAIL: pinksheet@centrasotaoms.com

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.
- I understand that by signing this authorization, my treatment, payment and enrollment or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- 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
02-05-2024