

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:	Date of Birth:	
Previous Name:	Patient Phone:	
I request and authorize		
Doctor or Clinic Name:	Phone:	
Address:		
City:	State:	Zip:
to release healthcare information of the patient named above to Maxillofacial and Oral Surgery, P.A. Please send the records to:		
Maxillofacial and Oral Surgery, P.A. 7-174 Moos Tower 515 Delaware Street SE Minneapolis, MN 55455-0329 Fax: 612-624-2669		
This information is needed for the purpose of collecting information related to ongoing medical treatment.		

Information to be released:

◆ **Complete Medical or Dental Record, or:**

◆ **Healthcare information relating to the following treatment, condition, or dates, or:**

◆ **Healthcare information limited to the following (please check all that apply):**

- | | | |
|---------------------------|---|--|
| ◆ Consultation Reports | ◆ Imaging/Radiology Films,
CD, reports | ◆ Photographs |
| ◆ Dental Models | ◆ Laboratory Results | ◆ Physicians Orders |
| ◆ Discharge Summary | ◆ Medication Records | ◆ Progress Notes |
| ◆ EKG/Echo Reports | ◆ Nursing Notes | ◆ Psychological
Tests/Psychiatric Records |
| ◆ Emergency Room Services | ◆ Operative Reports | ◆ Rehabilitative Services |
| ◆ Films/CD | ◆ Outpatient Clinic Records | ◆ Other (specify)
_____ |
| ◆ History and Physical | ◆ Pathology Reports/Slides | |

Special permission to release otherwise privileged information: please release records pertaining to:

(Check applicable conditions)

- | | | |
|--|---|---|
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Developmental Disabilities | <input type="checkbox"/> Alcohol Treatment/Evaluation |
| <input type="checkbox"/> AIDS/AIDS-Related Illness | <input type="checkbox"/> Drug Treatment/Evaluation | <input type="checkbox"/> HIV Test Results |

- I understand that this authorization will expire on the following date, event or condition: _____
- I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time by submitting a request in writing. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.
- I understand that the information will not be further disclosed to other entities without my consent except as outlined in Maxillofacial and Oral Surgery, P.A.'s Notice of Privacy Practices
- I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.
- I further understand that I may request a copy of this signed authorization. A photocopy of this release is valid to the same extent as an original.

Signature of Patient
or Authorized Person:

Date Signed:

(If authorized person is signing, please
indicate relationship/ authority to
sign):

Reason patient is
unable to sign:

Questions? Contact Maxillofacial and Oral Surgery, P.A. at 612-624-4435 or info@mospa.net, or visit our website at www.mospa.net