ORAL-
FACIAL
SURGERY,
P.A.

1029 19th Avenue SW
Willmar, MN 56201
320-235-1803
1-800-337-1778
Fax: 320-235-6097

301 North Third Street
Marshall, MN 56258
507-537-4176
1-866-837-2931
Fax: 507-537-4358

Authorization to Release Health Care Information

Patient's name: _____ Date of Birth: _____

I authorize and request the release of health information from:

Doctor's Name _____

Practice Name: _____

Release Information To:
Name/Doctor/Organization: _____

Address: _____

City, State: _____ Zip code: _____

This request and authorization applies to health care information relating to the following treatment, or condition:

_____

Service Dates (Optional):

From_____To_____

Information to be Release (Check all that apply)

- ☐ Radiology images
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Clinic Notes
- ☐ Billing Information
- ☐ All health care information
- ☐ Other:_____
  _____

THIS AUTHORIZATION EXPIRES ON _____ or _____DAYS AFTER THE DATE IT IS SIGNED; or WHEN THE FOLLOWING EVENT OCCURS _____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Health Care Information" or
- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____ _____
Signature of patient/Legal Representative Relationship to patient if signed by Legal Representative

_____ _____
Date Signed Witness Signature