ORAL
SURGERY
ASSOCIATES OF ALASKA, LLC
WWW.ORALSURGERYALASKA.COM
Ray A. Holloway, DDS

Authorization to Release Health Care Information

_____ _____ _____-_____-_____
Patient Name Date of Birth Social Security #

_____
Other Name Under Which Records Might Be Filed

_____ _____
Doctor Releasing Information Practice Releasing Information

I request and authorize the above listed doctor and practice to release health care information of the patient named above to:

_____
Name

_____
Mailing Address City State Zip Code

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

_____

☐ or ALL HEALTH CARE INFORMATION ☐ or 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 or Patient's Authorized Representative Date Signed

_____
Relationship Or Status If Signed by Parent, Legal Guardian, Personal Representative, Etc.