Oral Surgery Associates of Alaska

Authorization to Release Health Care Information

Patients Name: _____ Date Of Birth: ____/____/____

SSN: ___-____-___ Previous Name(s): _____

Doctor's name: _____ Practice Name: _____

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

Name: _____

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.

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.

_____

Signature of patient, legal guardian OR patients authorized representative Date signed

_____

Relationship or status if signed by parent, legal guardian, personal representative, etc.....