SOUTHEAST
ORAL & MAXILLOFACIAL
SURGERY ASSOCIATES

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip _____Phone _____

At my request, Southeast Oral & Maxillofacial Surgery Associates may release the following information:

☐ Entire record ☐ Financial records ☐ Office visit notes
☐ X-Rays ☐ On site record review by the patient

Entity or person who will receive the information:

Name _____

Address_____

City, State, Zip _____Phone _____

☐ **Send the information electronically. Email address: _____**

☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____Date _____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)

Revised May 2014