Casas Adobes Oral & Maxillofacial Surgery

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Authorization for Release of Medical Information

Today's Date: _____

Patient's Name: (Print) _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

Patient's Contact Numbers: Home ( ) _____ Work or Cell ( ) _____

Please ☐ Mail ☐Email ☐ Fax my records to:

☐ I authorize Casas Adobes Oral and Maxillofacial Surgery to **release information to:**

_____
Name of (Facility, Person, or Provider)

_____
Address

_____
City/State/Zip

_____
Phone Number

_____
Fax Number

☐ I authorize Casas Adobes Oral and Maxillofacial Surgery to **obtain medical records/information from:**

_____
Name of (Facility, Person, or Provider)

_____
Address

_____
City/State/Zip

_____
Phone Number

_____
Fax Number

Note: Medical Records are faxed in cases of medical necessity

Purpose of this request: ☐ Healthcare ☐ Insurance ☐Legal
☐ Personal ☐ Transfer of Care ☐ Other: _____

Type of Records Requested: Date Needed: _____

☐ Treatment Summary (includes history physical, lab, xray, pathology, and operative reports)

☐ All Records ☐ Progress Notes ☐ Imaging ☐ Lab/Pathology

Authorization Valid for: ☐ This request only ☐ One year from date of request

Signature: _____ **Date** _____
(Legal Guardian, Parent, or Legal Representative)

Relationship to Patient: _____

Please note it can take up to 15 business days to process requests