HIPAA AUTHORIZATION FORM

Elite Oral Surgery of Wellington

Authorization for Use and Disclosure of Protected Health Information

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Phone: _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize Elite Oral Surgery of Wellington to use and disclose my protected health information as described below:

Release information to (Name and relationship):

_____

_____

Types of information to be released:

__ Complete medical records __ Lab results __ X-rays/Images

__ Treatment notes __ Billing information __ Other: _____

Purpose of disclosure:

__ Continued care __ Insurance __ Personal __ Other: _____

This authorization will expire on: _____ (date or event)

If no date is specified, this authorization expires one year from signature date.

Patient Signature: _____ Date: _____

Legal Representative: _____ Relationship: _____