MEDICAL RELEASE FORM

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
TO DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY

I. Patient information

Patient's Name ______________________________

Date of Birth ______________ Last 4 of Social Security Number ______________

Patient's Mailing Address ______________________________

Telephone Number ______________________________

II. Information to be disclosed

I authorize HMH Oral and Maxillofacial Surgery Department to disclose my health information as follows, for service dates: ______________________________

- ☐ Entire Medical Record/Outpatient Clinical Record
- ☐ History and Physical(s)
- ☐ Operative Report(s)
- ☐ Discharge Summary
- ☐ Films
- ☐ Other ______________
- ☐ Pictures
- ☐ Laboratory Results
- ☐ Radiology and Imaging Reports
- ☐ Other Test Results ______________
- ☐ Pathology Slides, Blocks, or Reports

I understand that information used or disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

III. Information is to be disclosed to:

Alfi Oral, Dental Implant & Facial Surgery
6624 Fannin St, Ste 1710, Houston, TX 77030
(844) 253-4667

IV. Purpose of use or disclosure:

V. I authorize the disclosure of health information as described above. I understand:

- This authorization is valid for 180 days unless otherwise stated here: ______________
- A photocopy or fax copy of this authorization is as valid as the original.
- I may revoke this authorization, but the revocation will not apply to information that has already been released in good faith before the revocation was received.
- Treatment or payment may not be conditioned on my completion of this authorization form.

______________________________ ______________

Signature of Patient or Qualified Personal Representative* **Date**

***If signed by a Qualified Personal Representative, the following must be completed:**

Printed Name of Qualified Personal Representative: ______________________________

Legal Documentation Showing Authority to Act on Behalf of the Patient: ______________________________

(Example: Guardian of Patient, Executor of Estate)