ALASKA CENTER FOR
Oral + Facial Surgery

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# Authorization to Release Medical Information

PATIENT NAME:_____

I understand that as a referral based practice, Alaska Center for Oral + Facial Surgery will share my medical information with my healthcare providers, and have my permission to do so. Information may be shared verbally, written, and electronically (via email). In addition to these individuals and agencies, I grant permission to release information to the following:

NAME: _____

ADDRESS:_____

PHONE #: _____FAX #:_____

EMAIL ADDRESS:_____

NAME: _____

ADDRESS:_____

PHONE #: _____FAX #:_____

EMAIL ADDRESS:_____

NAME: _____

ADDRESS:_____

PHONE #: _____FAX #:_____

EMAIL ADDRESS:_____

Releasing my information to the specified entities is voluntary and at my request, and would confirm my patient relationship with Alaska Center for Oral + Facial Surgery and provide information about my location of received services as well as the type of services rendered.

I acknowledge and understand that by releasing this information to the specified entities above, it is possible for the information to be intercepted and read by other people, outside of the control of Alaska Center for Oral + Facial Surgery. I also understand that it may be required by law or by practice to share my information with others, not listed above and beyond the control of Alaska Center for Oral + Facial Surgery.

I understand that this release is valid when I sign it and that I may withdraw my consent to release information at any time either orally or in writing.

_____

Patient/Guardian Signature Date