Authorization to Release/Receive Health Care Information

Patient's Name _____

Date of Birth _____ SSN: _____

I request and authorize Lowell/Nashua Oral Surgery Associates to release/receive health care information of the patient named above to:

Name: _____

Address: _____

City, State: _____ Zip Code _____

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

Or _____ all health care information

Or _____ Other _____

THIS AUTHORIZATION EXPIRES ON _____ or _____DAYS AFTER THE DATE IT IS SIGNED: OR WHEN THE FOLLOWING EVENT OCCURS _____
_____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

I may revoke this authorization at any time by notifying Nashua Oral Surgery Associates, Inc in writing; however, such revocation does not affect any actions taken by Nashua Oral Surgery Associates, Inc before they received my written revocation.

Once a doctor gives out the information that I want released, I know that my doctor has no further control over the information. The individual or organization that I authorized to receive the information might redisclose it. Federal or state privacy laws may no longer protect the information.

_____

Signature of patient or patient's authorized representative Date signed

_____

Relationship or status if signed by parent, legal guardian, personal representative, etc.

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Chelmsford Oral Surgery Associates
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