Centennial Lakes Medical Building
7373 France Ave S Suite 602
Edina MN 55435-4552
Phone: 952-835-5003; Fax: 952-835-9598
Email: edina@omscmn.com

Dell Professional Building
7770 Dell Road Suite 100
Chanhassen, MN 55317-9316
Phone: 952-975-0605; Fax: 952-975-3808
Email: chan@omscmn.com

Wayzata Medical Building
250 N Central Ave Suite 126
Wayzata MN 55391-1293
Phone: 952-475-2266; Fax: 952-475-0637
Email: wayzata@omscmn.com

Savage Medical Building
6350 143rd St Suite 206
Savage MN 55378-2890
Phone: 952-435-4150; Fax: 952-435-7548
Email: savage@omscmn.com

ORAL & MAXILLOFACIAL SURGICAL CONSULTANTS, P.A.

AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Patient Information	**Patient Name**_____ **Date of Birth** _____/_____/_____
Information Released **From**	☐ Oral and Maxillofacial Surgical Consultants, P.A. ☐ Other: Individual Name _____ Phone ( ) - Organization Name _____ Fax ( ) - Address _____ City _____ State _____ Zip _____
Information Released **To**	☐ Oral and Maxillofacial Surgical Consultants, P.A. ☐ Other: Individual Name _____ Phone ( ) - Organization Name _____ Fax ( ) - Address _____ City _____ State _____ Zip _____
Information to be Released	☐ Xrays and imaging ☐ All records between _____/_____/_____ and _____/_____/_____ ☐ Billing records ☐ Please release my entire record ☐ Progress notes from my doctor ☐ *Other* _____
Method of Release	*Records may take up to five business days to process and prepare.* ☐ Mail to Recipient ☐ Pick up on _____/_____/_____ at the _____ location ☐ Other: _____
Purpose of Release	☐ Treatment/Continued Care ☐ Disability Determination ☐ Insurance Purposes ☐ Personal Use ☐ Litigation ☐ Other_____

The authorization expires (ends) on the following date, event or condition: _____
This authorization will expire no more than twelve (12) months from the date I sign this form, unless otherwise specifically permitted by law.

I understand that:

- I may revoke this authorization at any time by notifying, in writing, the healthcare facility listed above.
- Revoking this authorization does not apply to information that has already been released under this authorization.
- I have the right to inspect or obtain a copy of the health information to be disclosed.
- If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws. Information that goes to other persons/entities may not be protected by state or federal privacy laws and may be re-disclosed.
- I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as a life insurance company.

_____ _____
Signature of patient OR patient's representative *Signature Date*

If signed by patient's representative:

_____ _____
Printed name of representative *Relationship to patient*

_____ _____
Signature of witness *Printed name of witness*