AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:
Last Four of SSN:
Date of Birth:

I hereby freely authorize an appropriate workforce member of Susquehanna Oral and Maxillofacial Dental Implant Surgery* to release information from my medical record to:

_____
(name or title of the individual or name of organization to which disclosure is to be made)

Address: _____
(address of receiving party)

Telephone: _____ FAX: _____

How Much and What Kind of Information to be Disclosed/Released - (Place an X by those items to be released)

__ Discharge Summary	__ Medications	__Treatment Plan	__Progress in continuing care
__ Integrated summary	__ Lab, X-ray, EKG	__ Continuing care plan	__ FMLA/disability forms
__ History & Physical	__ PPD	__Prognosis	__Copy of Bill
__ Biopsychosocial	__ Orders	__ Presence in treatment	__ Family packet
__ Consults	__ Diagnosis	__Progress in treatment	__Other
__ Medication administration record	__ Progress notes	__ Nature of program	_____

The information to be released will cover the time period from _____ to _____
("present" equals date of signature)

Purpose of the Disclosure is For/To:

__ Continuity of Care	__ Settle Insurance Claim
__ Discharge/Continuing Care Planning	__ Keep Family/Significant Other Involved
__ Assist with Legal Issues	__ Keep Employer/School Involved
__ Fill Out FMLA/Disability Forms	__ Keep Referral Source Involved
__ Application for Insurance	__ Other _____

Method of Releasing this Information: ___ Telephone __ Mail __ Fax __e-secure email __ Hand Delivered by: _____
(name of person)

The consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payor. I will contact SOMFS immediately if I wish to revoke this authorization. As described in the Notice of Privacy Practices for SOMFS, I may request such Notice of Privacy Practices for the ease of reference. SOMFS may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (i) to provide research-related treatment to me, or (ii) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party. **If not previously revoked, this authorization will expire one (1) year after the date of my signature or on _____ (if other than one (1) year).** The release of information is limited to the person or organization named above and will not be used for any other purpose than that stated.

AUTHORIZATION SIGNATURES

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

If patient is unable to sign authorization form because of physical condition or age, complete the following: Patient is a minor or patient is unable to sign authorization because: _____

_____ _____
Parent/Legal or Personal Representative Signature Date

_____ _____
Witness Signature Date

"This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical, or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." **Protected by Pennsylvania and Federal regulations**.

COPY OF COMPLETED AUTHORIZATION FORM MUST BE OFFERED TO PATIENT. PATIENT ACCEPTED/REFUSED (please circle).

* Throughout this form the acronym "SOMFS" shall refer to Susquehanna Oral & Maxillofacial Dental Implant Surgery