EASTERN VIRGINIA
ORAL & MAXILLOFACIAL SURGERY

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____
Last First MI Maiden or Other Name

Date of Birth: ____/_____/_____ Phone: _____

Address: _____
Street Apt #

_____
City State Zip

Date(s) of Service: _____

☐ I authorize Dr. _____ to use and disclose my protected health information for his/her own purposes of treatment, payment, and healthcare operations.

☐ I authorize Dr. _____ to disclose the following health records related to the patient listed above:

Records:

- ◉ All Records
- ○ HIV/STD
- ○ Drug and Alcohol Related
- ○ Medical Records
- ○ Diagnostic Records (Labs, X-rays)
- ○ Treatment Records
- ○ Billing / Claims Records

Please release these records to:

Name: _____
Address: _____
_____
Phone: (_____) _____ Fax: (_____) _____

These records are being requested for the purpose of : _____

If the person or entity receiving this information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions, per your request and no longer protected by these regulations.

You may revoke this authorization in writing at any time by sending written notification to:

Medical Records Custodian
Eastern Virginia Oral and Maxillofacial Surgery
6033 Providence Road
Virginia Beach, VA 23464
Fax: 757-366-0482

Please note: Revocations do not apply to information that has already been disclosed prior to revocation being received. You may decline to sign this authorization. Declining to sign will not affect your ability to obtain treatment or your eligibility for benefits.

You have the right to receive a copy of this authorization. This authorization expires one year from the date of signing or on _____.

Patient or Legal Guardian Signature: _____ Date: _____

Print Patient or Legal Guardian Name and Relationship to Patient: _____