NELSON & WELLS
ORAL AND MAXILLOFACIAL SURGERY

AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL RECORDS

I hereby request and authorize **Nelson & Wells Oral and Maxillofacial Surgery** to release information of the individual named below:

Patient Name: _____
Address: _____
Phone Number: _____ DOB: _____

I authorize the information to be disclosed to and discussed with the following individual (s) or organization (s):

Name: _____
Organization: _____
Address: _____
Phone Number: _____

The type and amount of information to be disclosed is as follows: (specify dates where appropriate):

- Entire medical record, from date _____ to date _____
- Laboratory results, from date _____ to date _____
- X-Ray films and reports **(charges may apply)**
- Financial statements, including insurance and patient payment records.

I hereby release **Nelson & Wells Oral and Maxillofacial Surgery** from all liability and all claims of any nature whatsoever pertaining to the disclosure of information contained in my medical records.

I understand that this consent also includes disclosure of records relating **to drug or alcohol abuse, child abuse, HIV status and or mental health records** that are protected by virtue of provisions of the Federal regulations.

I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that I have a right to a copy of this authorization.

_____

Signature of Patient/Legal Guardian/Authorized Personal Representative Date

_____

Signature of Witness (Print Name) Date