BOULDER VALLEY
ORAL & MAXILLOFACIAL SURGERY

# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name: _____ Date: _____

Date of Birth: _____

I authorize Boulder Valley Oral & Maxillofacial Surgery to release my medical information to (family, friend, dentist, doctor, etc.):

Name: _____ Telephone: _____

Name: _____ Telephone: _____

Name: _____ Telephone: _____

Name: _____ Telephone: _____

Authorized information includes the following information:

1) Complete Chart
2) Discharge Summaries
3) Consult Information
4) Lab Work/Results
5) Other: _____

This authorization, as may be applicable, extends to any medical records/information covered by any privilege, including without limitation to psychiatric, psychological and mental testing and records; records relating to drug treatment and/or substance abuse; records related to sexually transmitted diseases and/or social service notes.

Patient or Guardian Signature: _____

Date: _____

## AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED

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