Casas Adobes Oral & Maxillofacial Surgery

John Schmidt, DMD Adam Kaiser, DMD

Rachael Prokes, DDS Cesar Rivera, DMD, MD Rachna Casteel, DDS

Andrew Cook, DMD Leah Turigliatto, DMD

Authorization for Release of Medical Information

Today's Date:_____

Patient's Name: (Print) _____ Date of Birth: _____

Address: _____

City/State/Zip Code:_____

Patient's Contact Numbers: Home:_____ Work or Cell: _____

Please ☐ Mail ☐ Email ☐ Fax my records to:

☐ I authorize Casas Adobes Oral and Maxillofacial Surgery to **release information to:**

_____
Name of (Facility, Person, or Provider)

_____
Address

_____
City/State/Zip

_____
Phone Number

_____
Fax Number

Note: Medical Records faxed in cases of medical necessity

☐ I authorize Casas Adobes Oral and Maxillofacial Surgery to **obtain medical records/information from:**

_____
Name of (Facility, Person, or Provider)

_____
Address

_____
City/State/Zip

_____
Phone Number

_____
Fax Number

Purpose of this request: ☐ Healthcare ☐ Insurance ☐ Legal ☐ Personal ☐ Transfer of Care ☐ Other: _____

Type of Records Requested: Date Needed: _____

☐ Treatment Summary (includes history physical, lab, xray, pathology, and operative reports)

☐ All Records ☐ Progress Notes ☐ Imaging ☐ Lab/Pathology

Authorization Valid for: ☐ This request only ☐ One year from date of request

Signature: _____ **Date:** _____
(Legal Guardian, Parent, or Legal Representative)

Relationship to Patient: _____

* *Please note it can take up to 15 business days to process requests* *