

Authorization for Use or Disclosure of Medical Records or Other Health Information

Written authorization from the patient is required by law. All items must be complete to be considered valid.

1. **Name:** _____ **Date of Birth:** _____

2. I authorize the use and/or disclosure of Medical Record or Other "Health Information" as described below.

a) Name and address of Organization or Person authorized to release the Health Information:

**To: Northpoint Oral Surgery
304 East Rand Road, Suite 200
Arlington Heights, IL 60004
info@northpointos.com
P: 224-770-3001
F: 224-425-5341**

Description of Health Information to be released:

Please see attached letter

c) This Health Information is being disclosed for: Ongoing Medical Care

- 3. I understand that the information to be released may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, HIV test results, developmental disabilities, and genetic testing results unless I give written instructions not to release such information.
- 4. I understand that I have a right to revoke this authorization at any time. If I want to revoke this authorization, I must do it in writing and present it to Northpoint Oral Surgery. I understand that the revocation will not apply to information that has already been released.
- 5. I understand that I have a right to inspect and/or receive a copy of the Health Information to be released and that I may be charged a fee for any copies of the medical records that I receive.
- 6. I understand that if I agree to sign this authorization I must be provided with a signed copy of this form.
- 7. This authorization will expire **One Year from Date Provided Below unless Date specified:** _____
- 8. I further understand that the information disclosed may be redisclosed by the recipient and may no longer be protected by the federal privacy rules.
- 9. I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment.

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Relationship to Patient

Signature of Witness