Jay Cagata, DMD, MD

ORAL-FACIAL & IMPLANT SURGERY

Authorization for Release of Medical Information (HIPAA)

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA). By signing this form, you authorize the release of medical and/or dental information as described below.

Patient Name: _____ Date of Birth: _____

Phone Number: _____

I authorize the above practice to release records to:

Name / Organization: _____

Phone / Fax / Email: _____

Address: _____

Information to be released (check all that apply):

☐ Entire Record

☐ Consultation Reports

☐ Radiographs / CBCT / Imaging

☐ Operative / Procedure Notes

☐ Implant Treatment Records

☐ Other: _____

Purpose of Disclosure (optional): _____

I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance upon it.

This authorization will expire 12 months from the date signed unless otherwise specified below.

Expiration Date or Event: _____

Signature of Patient / Legal Representative: _____ Date: _____

Relationship to Patient: _____

Staff Use Only: Date Received _____ Staff Initials _____

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