MAPLE GROVE CENTER FOR
RESTORATIVE SURGERY

AUTHORIZATION TO RELEASE INFORMATION

Patient's Name: _____ Date of Birth: _____

Patient's Social Security Number: _____

I hereby authorize Maple Grove Center for Restorative Surgery to:

_____ obtain from the following

_____ release to the following

Name: _____

Address: _____

The following documents/information from the records pertaining to services received.

Date of Service: _____

The documents to be released are as described or listed as:

_____

_____

_____

The records are required for the specific purpose of: _____

I understand that my authorization will remain effective from the date of my signature until _____, and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

Signature of patient or patient's designated representative:

_____ Date: _____

Witness: _____ Date: _____