ORAL & FACIAL SURGERY CENTER
620 W 32nd St
Joplin, MO 64804
417-621-0500
Bradley R. Burnett, DDS & Associates

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Full Name: _____

Patient's Date of Birth: _____ SS# _____

I HEREBY CONSENT AND AUTHORIZE THE ORAL & FACIAL SURGERY CENTER TO:

☐ OBTAIN FROM: ☐ RELEASE TO:

_____
(Name from whom records are to be obtained or to whom records are to be released)

City, State, Zip _____

Telephone Number :_____ Fax Number: _(_____)_____

SPECIFIC RECORDS TO BE RELEASED OR OBTAINED BY CHECKING BELOW:

____All medical records ____Operative report(s)

____Lab report(s) ____Pathology report(s)

X-ray report(s): Pano:____ Ceph:____ Model:____ CT:_____ MRI:_____

Other: (Please Specify)_____

I request records for the following purpose:_____

_____

I further release the physician and staff of Oral & Facial Surgery Center of Joplin from any liability arising from the release of this information to the above stated facility or person, provided that the said release is performed in accordance with the applicable law.

_____ _____
SIGNATURE OF PATIENT/GUARDIAN RELATIONSHIP TO PATIENT

_____ _____
SIGNATURE OF WITNESS DATE

A PHOTO COPY OF THIS REQUEST IS AS VALID AS THE ORIGINAL. SIGNATURE ON FILE WILL BE CONSIDERED VALID INDEFINITELY. THE FEDERAL RULES RESTRICT ANY USE OF INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT. (Revised 12/18/09)