***Oral & Maxillofacial Surgery Associates Of Chester County, LTD.***

AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL RECORDS

Patient’s Name Date

I hereby request and authorize the release of my records, without limitations, (which includes photocopies of medical and/or dental histories, x-ray findings, diagnosis, treatment, prognosis and financial records) for professional use only. These records will be kept confidential and used only by the below named individual or organization.

**I request that you release the above information to:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Fill in name of patient or subsequent doctor or attorney)

Address

City State Zip

Copy of Drivers License: Yes No Other photo I.D. copied:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REQUESTING:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s (or Legal Guardian’s) Signature Date

Witness Signature Date