Craig A. Stasulis, D.M.D., M.D.
Oral and Maxillofacial Surgery, Inc.
435 Willard Ave, Unit D, Newington, CT 06111

Authorization to Disclose Protected Healthcare Information

Patient Name _____ Former or Maiden Name_____
Date of Birth: _____ Social Security Number _____
Address: _____ City: _____ State: _____ Zip Code: _____

I authorize the doctor/practice and designated staff named below to release my protected health information

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax/ Email: _____

Information to be released:

□ All Records
□ Billing/Claims Records
□ Diagnostic Records (lab, x-ray, etc.)
□ Treatment Notes
□ Other: _____
□ HIV/STD Related
□ Drug/Alcohol Related

Please send the records indicated above to:

Craig A. Stasulis, D.M.D., M.D. Oral and Maxillofacial Surgery, Inc.
435 Willard Avenue · Unit D
Newington, CT 06111
Email: Lila@CASoralsurgery.com · Fax: 1-855-915-1519

You may **revoke this authorization** in writing at any time by sending written notification to the doctor/practice named in section two. **Please note: Revocations do not apply to information that has already been disclosed prior to revocation being received.**

You may decline to sign this authorization. Declining to sign will not affect your ability to obtain treatment or your eligibility for benefits unless this authorization is being performed solely to create information to be sent to another entity.

You have the right to receive a copy of this authorization. This authorization expires one year from date of signing or on _____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name Relationship to patient