Central Illinois Oral & Maxillofacial Surgery

Release of Medical Records

Patient's Name:_____

Patient's Birthdate:_____ Patient's SSN:_____

Patient's Address:_____

Patient's Phone Number:_____

Patient's

Primary Medical Physician:_____Phone:_____

Additional Medical Providers:
Name:_____Specialty:_____

Phone:_____Facility:_____

Name:_____Specialty:_____

Phone:_____Facility:_____

I authorize Central Illinois Oral and Maxillofacial Surgery (Dr. Thomas Fonner) to receive my requested medical records from your office in order to aid in my treatment. This requested information may include but not limited to my clinical notes, lab results or medical clearance.

_____ _____

Patient Signature Date

100 Greenview Dr. Ste B, Effingham, IL 62401 Phone: 217-540-5348 Fax: 217-540-5360