Coastal Oral Surgery Associates Dr. Jeffrey O. Capes, DMD, MD

Medical Information Contact Form

(HIPAA Release Form)

Name: ___________________________________

Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including:

1 diagnosis / treatment / clinical records

2 claims / account information / Financial

3 scheduling / appointment history

This information may be released to:

[ ] Spouse____

[ ] Child(ren)____

[ ]Other____

[ ] Information is not to be released to anyone.

This ***Contact Information*** will remain in effect until terminated by me in writing.

Messages / Confirming Appointments

Please call [ ] my home [ ] my work [ ] my cell [ ] email [ ] text

If unable to reach me:

[ ] you may leave a detailed message

[ ] speak to a family member

[ ] please leave a message asking me to return your call

[ ] ____

The best time to reach me is between_____________________

Signed: ___________________________ Date: ____/____/_____

Witness:__________________________ Date: ___/____/______