Coastal Oral Surgery Associates

Medical Information Contact Form

HIPAA Release Form

Name: _____
Date of Birth: _____/____/_____
Would you like a copy of our HIPAA Privacy Practices? [ ] Yes [ ] No

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: ___/____/_____