

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:

[] Dentist _____

[] 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

[] _____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____