Robert L. Coe, D.D.S., INC
140 S. Hickory St
Escondido, CA 92025

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

## (HIPAA Release Form)

( ) I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

( ) Spouse_____
( ) Children_____
( ) Parent (s) _____
( ) Other_____

( ) Information not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

## Messages

Please call ( ) My home ( ) My work ( ) My cell number_____
If unable to reach me:

( ) you may leave a detailed message
( ) please leave a message asking me to return your call
( ) _____

The best time to reach me is (Day) _____between (time) _____

Signed: _____Date:_____/_____/_____

Witness: _____Date:_____/_____/_____