Dr V Escobar
Oral Maxillofacial Surgery
Dental Implant Center

HIPAA RELEASE FORM

Patient Name: _____ Account #: _____

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including a Spouse or Significant Other).

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information and account balances.

Name	Relation	Phone #
Name	Relation	Phone #
Name	Relation	Phone #

MESSAGES

Please call me at (____)_____ ☐ Home ☐ Work ☐ Cell Phone

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking to return your call
- ☐ _____

_____ _____
Patient Signature Date