PORTLAND
ORAL & MAXILLOFACIAL SURGERY

Authorization to Discuss Personal Health Information (PHI)

Other than you or your doctors involved in your care, with whom may we discuss your Personal Health Information and billing information:

Name: ____ Relationship:______________

Phone:__________________________

Name: ____ Relationship:______________

Phone:__________________________

Name: ____ Relationship:______________

Phone:__________________________

Name: ____ Relationship:______________

Phone:__________________________

Patient signature:______________________________ Date:_______________

This is valid for one year

DOUBLE SIDED PLEASE SEE OTHER SIDE →

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Acknowledgement of Receipt of Notice of Privacy Practices

I have been informed of this office’s Notice of Privacy Practices.

Please note the Notice of Privacy Practices is posted in the waiting room and on our website. A paper copy is available upon request.

Name:_______________________________________

Signature:___________________________________

Date:____

You may refuse to sign this acknowledgement.

DOUBLE SIDED PLEASE SEE OTHER SIDE →