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Oregon Surgical Wellness

Authorization to Communicate

I authorize Oregon Surgical Wellness to communicate with the authorized parties listed about my medical care and billing:

Name: _____ Relationship:_____
Phone: _____

Name: _____ Relationship:_____
Phone: _____

Name: _____ Relationship: _____
Phone: _____

This authorization gives permission for verbal communication and does not give authorized party access to obtain medical records, or to sign on the patient's behalf. Release of Medical Records requires separate authorization from the patient.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless, otherwise revoked, this authorization will remain in effect for three years from the date of signing.

Patient Name (Please Print): _____ Date of Birth: _____

Patient Signature: _____ Date: _____