UMPQUA COMMUNITY HEALTH CENTER

Additional Information

PATIENT NAME:
Please provide a list of all the parties we may speak with or leave a message with regarding the patient's dental care, prescriptions, appointment scheduling, or payment information.
Name Relationship
Name Relationship
Name Relationship
Authorization period FROMTO, ORLIFETIME. (Please initial the correct space)
***THIS IS NOT A RELEASE FOR MEDICAL RECORDS. THIS IS ONLY FOR PERMISSION TO SPEAK WITH DESIGNATED FAMILY OR PERSONAL REPRESENTATIVES. The undersigned patient or individual acting on the behalf of the patient agrees as follows:
 I give permission for Umpqua Community Health Center to render needed treatment to the patient. I authorize payment of dental benefits to Umpqua Community Health Center for services rendered. I understand that I am responsible for all charges incurred through Umpqua Community Health Center.
I request that payment under the dental insurance program be made to the provider named on any bills for services furnished to me during the effective period of this authorization. I further permit a copy of this authorization to be used in place of the original.
Signature:Date: