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 FROM_____TO_____ **, OR** _____LIFETIME.

(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:

1. I give permission for Umpqua Community Health Center to render needed treatment to the patient.
2. I authorize payment of dental benefits to Umpqua Community Health Center for services rendered.
3. 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:_____