WOODINVILLE ORAL & MAXILLOFACIAL SURGERY, Inc.
Ralph K. Zech, D.D.S., M.S., P.S.
Fellow American College Oral & Maxillofacial Surgery, Board Certified
17000 140th Ave NE, #301
Woodinville, WA 98072

Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment for services.
Information on our Notice of Privacy Policies is available for your review.

Patient Name: _____

Patient/ Guardian Signature: _____ Date: _____

Consent to Leave Health Information

_____ May leave message on voicemail at home #: _____

_____May leave message on voicemail at work #: _____

_____Mayleave information with spouse (name): _____

_____May leave information with other family member (name):

_____

_____ May leave message on cellular phone #:_____

_____May leave message at different location #: _____

With my signature below I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change any of the phone numbers listed above.

Patient/Guardian_____Date_____

Guardian: please print name and your relationship to the patient

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