

Dr. Lee Willis, D.D.S.
2510 N.W. Kline St.
Roseburg, OR 97470



I Hereby Grant Permission To:

Yes No Use and disclose health information about me to provide me with medical treatment or services. Dr. Willis may disclose health information about me to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of me and/or my health.

Yes No Use and disclose health information about me so that treatment and services I receive at this office may be billed to and any payment may be collected from me, an insurance company or a third party. Dr. Willis may also tell my dental plan about treatment I am going to receive to obtain prior approval, or to determine whether my plan will cover the treatment

Yes No Leave appointment reminders on voice mail / answering machine at home and/or with adult family members.

Yes No Leave account information on voice mail/answering machine at home and/or with adult family members.

May we call you at work regarding:

Yes No Treatment

Yes No Payment

Signature

Date