Bryan R. Guthrie, D.M.D., P.C.
802 Molalla Avenue · Oregon City, OR 97045
(503) 656-2139

Privacy Notice Acknowledgment & Communication Authorization

Patient Name: _____

There may be times when Dr. Guthrie and staff may need to contact you regarding your appointments, dental care, financial information, appointments, or other communications. Please authorize of the following methods of communication:
I, authorize Dr. Guthrie and staff to contact me and leave detailed message(s) at the following location(s):

☐ home #:_____ ☐ work #:_____

☐ cell #:_____ ☐ email:_____

Preferred method to contact me regarding appointment reminder messages:_____

☐ I wish to name a representative(s) to act on my behalf and/or to speak with Dr. Guthrie and staff regarding my care, treatment, financial information, appointments or other communication.

Representative

Initial

Name _____ Relationship _____
Phone #_____ _____

Name _____ Relationship _____
Phone #_____ _____

☐ I **DECLINE** to name a representative to act on my behalf; please **DO NOT** discuss my care with anyone other than as allowed by HIPAA regulations. By signing I have received a copy of the Privacy Notice for this organization on today's date.

Name & relationship to patient if other than self: _____

Federal law requires that we provide you with a copy of our Privacy Notice. The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt for the Notice. If you have questions about the Privacy Notice, please feel free to ask anytime. The name and contact of the Privacy Officer is listed on your copy of the Privacy Notice & is posted in the front office lobby.

The Privacy Notice was Provided to

Patient Name: _____ **Date:** _____

The Patient was unable to acknowledge receipt of the Privacy Notice for the following reason:
Signed:_____