Oral & Maxillofacial Surgery Specialists, P.C.
8580 Scarborough Dr., Suite 240
Colorado Springs, CO 80920

HIPAA - PATIENT DISCLOSURE

PLEASE PRINT COMPLETE ANSWERS TO ALL QUESTIONS. This is a confidential record.

PATIENT _____ **DATE** _____
last name first name middle name

I wish to be contacted in the following manner (check all that apply):

Home or cellular telephone

OK to leave message with the detailed information

Leave message with call-back number only

Work telephone

OK to leave message with detailed information

Written communication

OK to mail to my home address

OK to mail to my work/office address

I allow you to give my clinical information to or answer questions from (check all that apply):

Spouse

Parent

Child

Other

None
