Patient Notification Form

Patient's Full Name:_____ **Date of Birth:**_____

If applicable, Name of Parent(s), Legal Guardian(s):_____

Home:_____ Okay to leave message? Yes/No **Detailed Message? Yes/No

Cell:_____ Okay to leave message? Yes/No **Detailed Message? Yes/No

Work:_____ Okay to leave message? Yes/No **Detailed Message? Yes/No

****Detailed message may contain medical and/or prescription information.**

Select One:

☐ **I do <u>not</u> want any information about my healthcare communicated to family members/caregivers.**

☐ **I give Oral & Maxillofacial Surgery Associates permission to verbally communicate to family members/caregivers listed below.**

Name:_____ **Name:**_____ **Name:**_____

Please check the box next to specific information that may be **<u>verbally</u>** communicated to the individual(s) listed above:

☐ Prescription Request ☐ Request/Confirm/Cancel Appointments
☐ Referral Request ☐ Other (specify):_____

If you would like to grant permission to Oral & Maxillofacial Surgery Associates to discuss AIDS/HIV, Alcohol and/or Drug Abuse, or Mental Health with anyone but yourself, please request a *Medical Release Form.*

This authorization will expire 5 years from the date it was signed. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Oral & Maxillofacial Surgery Associates
Dr. Mark Zajkowski, DDS, MD, FACS
20 Long Creek Drive, South Portland, ME 04106

Patient Signature:_____ Date:_____

Parent/Legal Guardian Signature:_____ Date:_____