Steven Gabel, MD, FACS
900 SE Oak Street, Suite 203
Hillsboro, OR 97123
PHONE 503.693.1118 FAX 503.640.6461

HIPAA COMMUNICATION FORM

Patient name :_____Date of birth: _____

I give permission for Dr. Gabel and/or his staff to send mail to the following address:

Address : _____

City:_____State: _____ Zip Code:_____

I give permission for Dr. Gabel and /or his staff to call me at the number(s) checked below :

- ☐ Home phone : _____
- ☐ Work phone : _____
- ☐ Cell phone : _____
- ☐ E-mail address : _____

Who may we speak with at your telephone number(s)? Please check all that apply:

- ☐ May speak to anyone who answers the phone.
- ☐ May speak only with spouse : Name : _____
- ☐ May speak with : _____ Relation : _____
- ☐ May not speak with anyone except myself .

Leaving a message on the phone, please check all that apply :

- ☐ May leave any message.
- ☐ May identify yourself and leave a number to return call.
- ☐ Do not leave any message on my answering machine.

_____ _____

Patient Signature Date