



**Bruce Wojciechowski, O.D., F.C.O.V.D.**  
**John Reski, O.D., F.C.O.V.D.**  
**Rachel Jorgensen, O.D., F.C.O.V.D.**  
**Julia Sirianni, O.D.**  
**Macson Lee, O.D., F.C.O.V.D.**

15259 S.E. 82nd Dr., Suite 101 / Clackamas, Oregon 97015  
503.657.0321 / Fax: 503.657.7066  
1401 S.E. 164th Ave., Suite 100 / Vancouver, Washington 98683  
360.546.2046 / Fax: 360.574.5576  
10970 S.W. Barnes Rd. / Beaverton, Oregon 97225  
503.214.1396 / Fax: 503.469.0766  
www.doctorbruce.net

## RE: Patient Privacy

We are required by law to protect the privacy of your medical information. This means that we are not allowed to discuss any of your medical information with anyone other than yourself. This statement refers to personal *and* professional sources. If there is anyone that you would like us to share this private information, please fill in the following information. This form will remain in effect until the undersigned has removed the authorization in writing or by completing an updated form.

### *Personal Contacts:*

1.  
\_\_\_\_\_  
Name Relationship

2.  
\_\_\_\_\_  
Name Relationship

### *Professional Contacts:*

1.  
\_\_\_\_\_  
Name Specialty

2.  
\_\_\_\_\_  
Name Specialty

\_\_\_\_\_  
**Patient Name:**

\_\_\_\_\_  
**Signature Of Patient Or Guardian**

\_\_\_\_\_  
**Date**

**Declined**

*\*Please complete signature area if declining also\**