

**JEROME R. POTOZKIN, M.D. & MONICA K. BRAR, M.D.**

600 San Ramon Valley Blvd, Suite 102  
Danville, CA 94526  
925-838-4900  
925-838-4920 Fax

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/ SIGNATURE ON FILE  
6 Year Consent Form (must be updated if patient is not seen in a 2-year period)**

I hereby authorize Dr. Potozkin to use and disclose my individually identifiable health information ("Health Information") in the manner described below. I understand that if the person or entity authorized by this document to receive my Health Information is not a health plan or health care provider, then the disclosed Health Information may no longer be protected from further disclosure by state or federal law.

Messages may be left on my home answering machine for the following types of appointments:  Medical  Cosmetic

Detailed messages regarding test results (or) advice may be left on my home answering machine: YES NO

Detailed messages regarding test results (or) advice may be left on my work voice mail: YES NO

Medical Information can be discussed with:  Patient Only  Family Member  Friend

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Information can be released or faxed to my :  Physicians  Insurance Company  Pharmacy

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Account/Billing information can be released to:  Patient Only  Family Member  Friend  Other

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

I have an advance health care directive: YES NO

In the event you are not able to speak, an Advance Health Care Directive, a legal document states your healthcare treatment plan and allows an appointed person to represent you.

I give Dr. Potozkin permission to send a thank you letter to the person who referred me: YES NO

**PLEASE READ & INITIAL**

\_\_\_\_ I understand that I am financially responsible for all cosmetic charges at the time of service.

\_\_\_\_ I understand that I am financially responsible for all medical charges whether or not paid by health insurance.

\_\_\_\_ I understand that I am responsible for understanding my medical insurance benefits and coverage.

\_\_\_\_ I understand that I am responsible for obtaining all authorization for follow-up visits.

\_\_\_\_ I understand my medical insurance may not pay for routine labs (or) pathology tests (including biopsies).

\_\_\_\_ By signing, I authorize Dr. Potozkin's billing service (CMI) to submit medical claims to my insurance plan(s).

\_\_\_\_ I authorize Dr. Potozkin's office to act as my agent in helping me obtain payment from my insurance company.

\_\_\_\_ I authorize payment directly to Dr. Potozkin's office.

\_\_\_\_ I have been given a brochure of the **Notice of Privacy Practices**, a federal privacy law created as a result of Health Insurance Probability Accountability Act of 1996 (HIPAA), (effective April 14, 2003).

Patient Name (PRINT): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed by patient, please indicate relationship:  Parent, if patient is under 18 yrs of age  Guardian, if patient is under 18 yrs of age  
 Guardian or conservator of an incompetent patient  Beneficiary or personal representative of deceased patient