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

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AUTHORIZATION FOR THE 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 / Dr. Brar to use and disclose my individually identifiable protected health information ("PHI") 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 cell / home phone 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

Detailed messages regarding test results (or) advice may be left on my cell phone: ☐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: ☐Physician ☐Insurance Company ☐Pharmacy

Physician's 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 *We do not honor advanced directives.*

I give Dr. Potozkin / Dr. Brar permission to send a thank you letter to the person who referred me: ☐Yes ☐No

PLEASE READ AND 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 my medical insurance may not pay for routine labs (or) pathology tests (including biopsies).

_____ By signing, I authorize Dr. Potozkin's / Dr. Brar's billing service (Aesyntix Billing Solutions) to submit medical claims to my insurance plan(s).

_____ By signing, I authorize Dr. Potozkin's / Dr. Brar's office to mail to my home any items that assist the practice, such as appointment reminder cards and statements, as long as they are marked *Personal and Confidential.*

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

_____ I authorize payment directly to Dr. Potozkin's / Dr. Brar's office.

_____ I have been given the **Notice of Privacy Practices**, a federal privacy law created as a result of Health Insurance Portability and Accountability Act of 1996 (HIPAA), (Revised 9/23/13).

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

We have a rule in our practice; it's called the "No Jerks Rule". You might have a similar rule in your dealings (we hope so!). Life is too short to work with people who treat you poorly. We only serve patients who are polite, professional and respectful. You can expect us to treat you with dignity and respect at all times. We expect the same, no exceptions.