JEROME POTOZKIN, M.D.
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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