

● CONSENT TO RELEASE OF INFORMATION ●
 ● ACCEPTANCE OF FINANCIAL RESPONSIBILITY ●
 ● HIPAA ACKNOWLEDGEMENT ●

◆ I authorize Central Coast Institute for Plastic Surgery to release all medical records pertaining to medical history, services rendered or treatment for me or my dependents for insurance claims.

◆ I authorize direct payment of medical benefits to Central Coast Institute for Plastic Surgery.

◆ I agree as guarantor for the above patient or as the patient, to pay for medical services at the time of service, unless prior arrangements have been made.

◆ I understand that I am ultimately responsible for payment of medical services provided to me or my dependent, regardless of my insurance status, including co-payments, deductibles, co-insurances, and any amounts above my insurance's allowable and non-covered or denied services.

◆ I have reviewed Central Coast Institute for Plastic Surgery's *Notice of Privacy Practices* pursuant to the *Health Insurance Portability & Accountability Act* of 1996 (HIPAA). I understand Central Coast Institute for Plastic Surgery has the right to change its notice from time to time and I have to right to contact this organization at any time to obtain a current copy.

Do you wish correspondence to be confidential? Yes No

Do you wish phone calls to be confidential? Yes No

I hereby authorize Central Coast Institute for Plastic Surgery to discuss my medical and payment information with:

1. _____ Relationship _____

2. _____ Relationship _____

3. _____ Relationship _____

Patient/Guardian Signature

Date

Relationship

Do you have any current medical conditions for which you are under treatment by a physician?

No Yes, Explain:

Please list below any family history of medical problems:

Mother: _____

Sister: _____

Father: _____

Brother: _____

Other: _____

Other: _____

Are there any other medical disclosures you would like the physician to know or that might be helpful in your medical care? No Yes, explain:

I declare that I have disclosed all requested medical information honestly and completely to Central Coast Institute for Plastic Surgery to the best of my knowledge.

Print Name (Patient)

Patient Signature

Date