

ACKNOWLEDGMENT OF CONSENTS, RELEASES, AND AGREEMENTS

Date of Birth

Patient Name (please print)

Notice of Uses and Disclosures o	of Protected Health Information	
necessary to use and disclose he		CPSA) to deliver the best service it may be ave the right to receive and review a written
nformation as well as my individu nsurance matters, or in the perfor eceived by CPSA may be in the f	al rights and the duties of CPSA that r mance of health care operations of CPS	ses and disclosures of my protected health may occur in my treatment, payment of bills, SA. This health care information, created or nic or paper records, may include information
		Privacy Practices from time to time, and that I by in the mail or by requesting one at the time
By signing below, I agree that I have	e reviewed and understand the information	on above.
Date:		
Patient Signature:		
(Patient representative)	(Representative	's Authority)
AUTHORIZATION TO	RELEASE MEDICAL INFORMA	TION TO FAMILY MEMBERS
	n cannot be released without specific autl OT authorize the release of the blank sp	
Surgery and home instructions	Scheduled appointments	Treatments (fillers, Botox, peels)
Insurance matters/billing	Payment for services	
I authorize the CP	SA to discuss my information related	to the initialed services with:
	Name/Relationship	Name/Relationship
	Name/Relationship	Name/Relationship