

MEDICAL INFORMATION RELEASE AUTHORIZATION

Patient Name: _____ Date of Birth: _____

By signing this form I authorize Dr. Jan Garcia, Jr. to release confidential health information about me either by releasing a copy of my medical records, summary or narrative or verbal release to the person or entity listed below.

Release my protected health information to the following person (s) / entity:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature (Patient, Legal Guardian, Legal Representative)

X _____ Date: _____

PHOTOGRAPH AUTHORIZATION

**** Photographs are not taken of every patient but a consent form must always be on file.**

In connection with the medical service I am receiving from my physician, Jan Garcia, Jr., M.D., I consent that photographs may be taken of me or part of my body under the following conditions:

- The photographs may only be taken by my physician
- The photographs shall be used as medical records.
- These photos are not used for advertisement or general news media.

Patient/Parent/Guardian Signature Date: _____

Witness: _____ Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

My signature below indicates that I have read and understand the Notice of Privacy Practices for Plastic Surgery Arts Center. I recognize that outside of purposes for treatment, for payment, and for certain healthcare operations I must give my written authorization to release any of my protected healthcare information unless otherwise specified. I understand that if I do not consent the release of my healthcare information, services might not be performed by Dr. Jan Garcia, Jr.

Patient/Parent/Guardian Signature Date: _____

Patient/Parent/Guardian Printed Name