ANDOCHICK CENTER FOR COSMETIC SURGERY LLC
Scott E. Andochick, MD
81 Thomas Johnson Ct. Suite A Frederick, MD 21702

ACKNOWLEDGMENT OF RECEIPT OF GENERAL NOTICE – FORM 1

I acknowledge that I was provided with a copy of the General Notice of my rights regarding release of my medical records.

_____ _____
Name of Patient (printed) Date

_____
Signature of Patient (or legally responsible individual)

GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS – FORM 2

I acknowledge that I was provided with a copy of the General Authorization for Release of Medical Records, and that these policies may be changed by the provider and I will be given an update notice if this occurs.

_____ _____
Name of Patient (printed) Date

_____ _____
Signature of Patient (or legally responsible individual) Date

_____ _____
Witness Date

DISCLOSURE TO FAMILY/FRIENDS

_____ I do not want ANDOCHICK CENTER FOR COSMETIC SURGERY LLC ("Provider") to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

_____ I authorize Provider to disclose information related to my care and treatment to the following named individual(s):

_____ _____

_____ _____

The authorizations provided for above are subject to the following limitations or restrictions:

_____

_____

_____ _____
Patient Name (Printed) Signature of Patient (or legally responsible individual)

_____ _____
Witness Date