MR#

RELEASE OF INFORMATION

I hereby authorize Dr. Dennis Foster to furnish a copy of medical records or information contained within the medical records to the following:

_____

_____

_____

The information authorized for release may include information which may not be considered a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency syndrome (AIDS).

Patient Signature: _____ Date: _____

AUTHORITY TO DISCUSS PATIENT MEDICAL CONDITION

I hereby authorize Dr. Dennis Foster and/or staff to discuss my medical condition with the following person (s):

_____

_____

_____

Patient Signature: _____ Date: _____

OFFICE PRIVACY POLICY

I hereby acknowledge that I have been furnished a copy of Dr. Dennis Foster's PRIVACY POLICY and have read the entire contents of this policy.

Patient Signature: _____ Date: _____

GUARANTY OF ACCOUNT

I understand that I am responsible for charges incurred for medical care. It is the policy of this office to file insurance for those charges which insurance coverage is expected to pay.
I understand that I will be billed and be held responsible for those charges that are not covered by insurance or those charges above what insurance pays.

Patient Signature: _____ Date: _____

BENEFITS TO PHYSICIAN

I hereby authorize payment directly to Dr. Dennis Foster for services covered and paid by insurance and/or other third party payers.

Patient Signature: _____ Date: _____