Central Coast
Head and Neck Surgeons

Authorization Release

I authorize the release of any information necessary to process insurance claims or obtain reimbursement. I request that payment of authorized benefits be made directly on my behalf to Central Coast Head and Neck Surgeons, Inc. This assignment will remain in effect until revoked by me in writing. I further understand that I am financially responsible for copayments and charges not paid by insurance.

Additional Charges: This is a specialty office; we do procedures to determine your diagnosis. You are responsible for the additional charges or procedure copay if your insurance does not cover anything outside of an office visit. This is in addition to your copay. Any outside lab or diagnostic services will be an additional charge from the corresponding facility.

Signature: _____

Relationship To Patient: _____

Date: _____

This office has the **Notice of Privacy Practices Brochure** (which is attached to your registration forms), commonly known as **HIPAA**, available to our patients. Please let our office staff know if you would like one for your information and initial the section that applies to the action taken. This notice describes how medical information about the patient may be used and disclosed and how you can get access to this information. Please review it carefully.

☐ I have chosen to accept the Notice of Privacy Practices Brochure

☐ I have declined to accept the Notice of Privacy Practices Brochure