PROLIANCE SURGEONS®

Acknowledgement of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information.
By signing, you acknowledge that you have reviewed or have been offered the Notice of Privacy Practices of Proliance Surgeons, Inc., P.S.

I hereby authorize my insurance benefits be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release information required for this claim. I consent to the release of medical information from or to other doctors and health care institutions as is necessary to my care and treatment

_____ _____
Signature of Patient or Guardian Date Time

_____ _____
Printed Name DOB