



ALASKA BREAST &
COSMETIC CENTER

Health. Hope. Confidence.

1. **CONSENT TO TREAT:** I hereby consent to permit Dr. Mary Jo Wright to render medical services and counsel to me. I authorize the release of any medical information necessary for my medical treatment.
2. **NOTICE OF PRIVACY PRACTICES:** I have been presented with a copy of the Notice of Privacy Practices for Dr. Wright detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.
3. **RESPONSIBILITY FOR PAYMENT:** I authorize the release of any medical information necessary to process my insurance claims. I authorize payment directly to my medical doctor for services described on any claim forms filed on my behalf.
****I will be fully responsible for all charges not paid by my insurance company****
4. **PRESCRIPTION HISTORY CONSENT:** We are utilizing Escribe and will be reviewing your prescription history. I authorize Dr. Mary Jo Wright to obtain my prescription history.

I acknowledge that I have read and fully understand the above information and have no questions.

PATIENT NAME – Print (Please print name of parent or legal guardian if minor)

PATIENT SIGNATURE – Signature of parent or legal guardian

DATE