PRIVACY PRACTICES ACKNOWLEDGEMENT/MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE FORM)

Patient Name: Date of Birth:

I have been provided an opportunity to review the Notice of Privacy Practices, and understand the policy as written. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, FreshSkin may decline to provide treatment to me.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices. If changes to the policy do occur, this medical spa will provide me a revised Notice of Privacy Practices upon my request.

FreshSkin may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the medical spa in carrying out treatment, payment or other healthcare operations.

FreshSkin may mail to my home or other designated locations any items that assist the medical spa in carrying out treatment, payment or other healthcare operations.

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

*Please allow 5-7 business days to process your medical records request.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

ACKNOWLEGEMENT

By signing this form, I am consenting to FreshSkin's use and disclosure of my protected health information to carry out treatment, payment and other healthcare operations.

Signed: ____ Date: ____/____/_____

Witness:____ Date: ___/____/_____