OLYMPIA AESTHETICS

Date: _____

Name: _____
First Middle Last

Address: _____
Street City State Zip

Telephone: _____ _____
Primary Secondary

May we leave a message on your phone(s)? [ ] Primary [ ] Secondary

Email: _____ Referred By: _____

Date of Birth: _____ Height: _____ Weight: _____ Gender : [ ] Male [ ] Female [ ] Other

Occupation: _____ Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

With whom may we share your medical information? _____

**Emergency Contact Information**:

Name: _____ Relationship: _____

Telephone: _____

**Please list all medications & dietary supplements**, including prescription, over-the-counter medications, birth control, Aspirin, vitamins, herbal supplements (e.g., Fish oil, Saw palmetto, Flax seed oil, St. John's Wort, etc.)
[ ] **I do not take any medications or dietary supplements**.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

OLYMPIA AESTHETICS

**Please list all allergies & reactions** (e.g., Shellfish- Anaphylactic shock, Latex- Rash, Penicillin- itching, etc. )
[ ] **I do not have any allergies I am aware of**.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

**Personal Health History**: Do you or have you had any medical conditions?

[ ] **No Conditions I am aware of**
[ ] High blood pressure
[ ] Heart Disease
[ ] Heart Failure
[ ] Heart Attacks
[ ] Chest Pain (angina)
[ ] Seizures
[ ] Cancer, type: _____
[ ] Diabetes
[ ] Kidney Disease
[ ] Liver Disease
[ ] Thyroid Disease
[ ] Stomach Problems
[ ] Gastric Reflux
[ ] Psychiatric Diagnosis (Body dysmorphic disorder, depression, anxiety, etc.)
[ ] Asthma
[ ] Emphysema
[ ] Stroke
[ ] Hepatitis
[ ] HIV/AIDS
[ ] Bleeding Problems
[ ] Other: _____

Previous Surgeries (including dates): _____

Have you had any previous cosmetic treatments or procedures? [ ] Yes [ ] No
If yes, please list:
_____

Do you have any history of keloid or hypertrophic scarring? [ ] Yes [ ] No

Do you have any history of Herpes or cold sores? [ ] Yes [ ] No

Have you ever had an adverse reaction to cosmetic treatments? [ ] Yes [ ] No
If yes, please list:
_____

Current or Recent Illnesses: _____

Are you pregnant or breastfeeding? [ ] Yes [ ] No

Do you have any known skin conditions (e.g., eczema, psoriasis)? [ ] Yes [ ] No

OLYMPIA AESTHETICS

**Primary Care Information**:

Primary Care Provider : _____Date of last Physical Exam:_____

**Additional Medical Providers**: Do you regularly see a specialist or another Medical Provider (e.g., Cardiologist, Neurologist, Dermatologist, Psychiatrist, Oncologist, etc.)? If so, please list the provider below.

[ ] **I do not see any other specialist (s)**

Medical Provider: _____
Provider Name Specialty Phone Number

Medical Provider: _____
Provider Name Specialty Phone Number

Please list the information for you preferred Pharmacy

Preferred Pharmacy: _____ Telephone: _____

Address: _____
Street City State Zip

**Social History: Please Select all that apply**.

Drugs: Do you or have you used any of the following:

Tobacco products [ ] Yes [ ] No

If yes, for how long? _____, how many packs/day? _____

If you are a former smoker, what year did you stop? _____

Vape or Electronic cigarettes [ ] Yes [ ] No

If yes, for how long? _____

If you are a former vap or electronic cigarette smoker, what year did you stop? _____

Nicotine gum/patch or any type of smoking aid [ ] Yes [ ] No

If yes, for how long? _____, list products used _____

Illicit drugs [ ] Yes [ ] No

If yes, for how long? _____, which drug(s)? _____

If you are a former illicit drug user, what year did you stop? _____

**Alcohol Consumption: How often do you consume alcohol?**

[ ] Never, I do not drink alcohol
[ ] Rare, 1-2 drinks a week
[ ] Moderate, 7-10 drinks a week
[ ] Heavy, daily or 10+ drinks a week

**Diet & Exercise**

How would you rate your eating habits? [ ] Poor [ ] Fair [ ] Good [ ] Excellent

Do you exercise? [ ] Yes [ ] No

If yes, how many days/week? _____ How many minutes/session? _____

Have you experienced significant **weight loss**? [ ] Yes [ ] No

If yes, how much weight loss? _____ Over how much time? _____

Have you experienced significant **weight gain**? [ ] Yes [ ] No

If yes, how much weight gain? _____ Over how much time? _____

**<u>Systems Review</u>: Please select "Yes" for all that apply and "no" for those that do not apply**.
Do you have (or have you ever had) any of the following conditions/illnesses/symptoms:

**Cardiovascular**
Heart bypass surgery [ ] Yes [ ] No
Pacemaker [ ] Yes [ ] No
Irregular Heartbeat [ ] Yes [ ] No
Heart Murmur [ ] Yes [ ] No
High Blood Pressure [ ] Yes [ ] No
Heart Attack [ ] Yes [ ] No
Chest pain/Angina [ ] Yes [ ] No
Heart Failure [ ] Yes [ ] No

**Neurological**
Fainting [ ] Yes [ ] No
Dizziness [ ] Yes [ ] No
Headache/Migraine [ ] Yes [ ] No
Double vision [ ] Yes [ ] No
Stroke [ ] Yes [ ] No
Seizures [ ] Yes [ ] No

**Endocrine**
Steroid use [ ] Yes [ ] No
If yes, [ ] Anabolic steroids
[ ] Other

**Diabetes**
Thyroid Disease [ ] Yes [ ] No
Immunosuppressant drugs [ ] Yes [ ] No
Hormone Replacement Therapy [ ] Yes [ ] No

**Hematology/Oncology**
Bleeding tendency [ ] Yes [ ] No
Easy bruising [ ] Yes [ ] No
Anemia [ ] Yes [ ] No
Sickle Cell Disease [ ] Yes [ ] No
Blood Clots [ ] Yes [ ] No
If yes, [ ] Legs [ ] Lungs
Radiation Therapy [ ] Yes [ ] No

**Infectious Gastrointestinal**
Hepatitis [ ] Yes [ ] No
Heartburn [ ] Yes [ ] No
Jaundice [ ] Yes [ ] No
Ulcers [ ] Yes [ ] No
Hiatal Hernia [ ] Yes [ ] No

**Respiratory**
Abnormal Chest X-ray [ ] Yes [ ] No
Acute Bronchitis [ ] Yes [ ] No
Recent Chest Infection [ ] Yes [ ] No
Shortness of Breath [ ] Yes [ ] No
Asthma [ ] Yes [ ] No
COPD [ ] Yes [ ] No
Sleep Apnea [ ] Yes [ ] No
Cough [ ] Yes [ ] No

**Psychiatric (*Medically Diagnosed)***
OCD [ ] Yes [ ] No
Depression [ ] Yes [ ] No
Anxiety [ ] Yes [ ] No
Psychiatric Care [ ] Yes [ ] No
Body Dysmorphic Disorder [ ] Yes [ ] No

**Musculoskeletal**
Fibromyalgia [ ] Yes [ ] No
Sciatica [ ] Yes [ ] No
Herniated Disc [ ] Yes [ ] No
Arthritis [ ] Yes [ ] No
Rheumatoid [ ] Yes [ ] No
Neck, back, arm, leg problems [ ] Yes [ ] No

**Urinary**
Urinary Disease
Kidney Disease
If yes, are you on dialysis? [ ] Yes [ ] No

**Skin**
Melanoma [ ] Yes [ ] No
Staph Infection [ ] Yes [ ] No
Skin Cancer [ ] Yes [ ] No
Keloid/Hypertrophic Scarring [ ] Yes [ ] No

**Eyes**
Cataract [ ] Yes [ ] No
Glaucoma [ ] Yes [ ] No
Double Vision [ ] Yes [ ] No
Droopy Eyes [ ] Yes [ ] No

**<u>Systems Review</u>: (*Continued*) Please select all that apply.**
Do you have or have you ever had any of the following conditions/illnesses/symptoms:

**Reproductive**
History of breast cancer[ ] Yes [ ] No
If yes, [ ] Familial [ ] Personal
If personal, [ ] Left Breast [ ] Right Breast
Treatment: [ ] Radiation, for how long? _____
[ ] Chemotherapy, for how long? _____
[ ] Other
If familial, [ ] Maternal [ ] Paternal
Are you/could you currently be pregnant? [ ] Yes [ ] No
Number of pregnancies: _____

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**How did you hear about Olympia Aesthetics?**
[ ] Internet – Google, Website, Yelp, Facebook, Instagram, YouTube: _____
[ ] Patient referral. Please provide name: _____
[ ] Doctor referral. Please provide name: _____
[ ] Other – Event, Newsletter, TV/Media _____

**Current facial concerns you currently experience or would like to discuss**

[ ] Acne
[ ] Acne scarring
[ ] Anti-aging
[ ] Broken blood vessels
[ ] Crow's feet
[ ] Double chin/Turkey Neck
[ ] Enlarged pores
[ ] Forehead lines
[ ] Freckles & pigmentation
[ ] Fine lines and wrinkles
[ ] Gummy smile
[ ] Loss of facial definition and contours
[ ] Marionette lines
[ ] Melasma
[ ] Nasolabial folds/smile lines
[ ] Rosacea or redness
[ ] Temple hollows
[ ] Thin & short eyelashes
[ ] Under eye circles
[ ] Vertical lip lines
[ ] Volume loss
[ ] Weak chin

**Current body concerns you currently experience or would like to discuss**

[ ] Aging hands
[ ] Brown/sun spots
[ ] Chest veins
[ ] Chest wrinkles
[ ] Excessive hair
[ ] Excessive sweating
[ ] Hair maintenance
[ ] Improve skin tone & texture
[ ] Loose skin
[ ] Sagging knees
[ ] Scars
[ ] Stretchmarks

**Any other additional services you would like to learn about?**

[ ] Botox/Dysport/Xeomin
[ ] Chemical Peels
[ ] Collagen Stimulators (Sculptra/Radiesse)
[ ] Custom skincare regimen
[ ] Filler
[ ] Laser Treatment
[ ] Microneedling
[ ] Non-surgical brow lift
[ ] PRF Hair Restoration
[ ] Skin Resurfacing
[ ] VISIA Skin Analysis

**Are you prone to any of the following?**

**[ ]** Fragrance sensitivities
[ ] Dark spots
[ ] Dryness
[ ] Redness & sensitivity
[ ] breakouts

OLYMPIA AESTHETICS

# Medical Dermatology Questionnaire

What was the date of your last full body skin check?
[ ] Never had [ ] Date _____

Have you or anyone in your family ever been diagnosed with skin cancer?
[ ] Yes [ ] No [ ] Not sure

What is your current skincare regimen/routine?
a.m. _____
_____
p.m. _____
_____

Products Used (include brand names):
_____

Skin Sensitivity or Allergies to Skin Care Products:
_____

Previous Cosmetic Procedures (e.g., Botox, fillers, chemical peels, microneedling, etc.):
_____

Sun Exposure and Sunscreen Use:
_____

**Consent and Agreement**: I understand that the information provided in this intake form is essential for my treatment planning and safety. I have disclosed all relevant medical history, medications, and allergies to the best of my knowledge. I acknowledge that my treatment options will depend on this information.

I agree to follow all pre- and post-treatment instructions provided by Olympia Aesthetics. I understand that results vary, and there are no guarantees of specific outcomes.

**Patient's Signature**: _____ **Date**: _____

OLYMPIA AESTHETICS

# Fitzpatrick Skin Typing Questionnaire

| Name: | | | | Date: | | |
|---|---|---|---|---|---|---|
| **Score** | | **0** | **1** | **2** | **3** | **4** |
| | **What is the natural color of your eyes?** | **Light Blue, Gray or Green** | **Blue, Gray, or Green** | **Blue** | **Dark Brown** | **Brownish Black** |
| | **What is your natural hair color? (Prior to gray or white)** | **Sandy Red** | **Blonde** | **Chestnut, Dark Blond** | **Dark Brown** | **Black** |
| | **What is the color of your unexposed skin? (stomach, thighs)** | **Reddish** | **Very Pale** | **Pale with Beige Tint** | **Light Brown, Olive** | **Dark Brown** |
| | **Do you have freckles on sun exposed areas? (lower arms, face)** | **Many** | **Several** | **Few** | **Incidental** | **None** |
| | **What happens when you stay in the sun too long?** | **Painful Redness, Blistering, Peeling** | **Blistering Followed by peeling** | **Burns sometimes followed by some Peeling** | **Rare Burns** | **Never Burns** |
| | **How easily do you turn brown or tan?** | **Hardly or Not at all** | **Light color Tan** | **Reasonable/ moderate Tan** | **Tan Very Easily** | **Turn Dark Brown Quickly** |
| | **Do you turn brown or tan easily several hours after sun exposure?** | **Never** | **Seldom** | **Sometimes** | **Often** | **Always** |
| | **How does your face react to the sun?** | **Very Sensitive** | **Sensitive** | **Normal** | **Very Resistant** | **Never had a Problem** |
| | **When did you last expose your skin to the sun? (tanning bed, use of self-tanning creams, or sun-bathing)** | **More than 3 Months ago** | **2-3 Months ago** | **1-2 Months ago** | **Less Than 1 Month ago** | **Less than 2 Weeks ago** |
| | **Do you intentionally expose the area to be treated to the sun?(tanning bed, use of self-tanning creams, or sun-bathing)** | **Never** | **Hardly Ever** | **Sometimes** | **Often** | **Always** |

Total Score: _____ Fitzpatrick Type: _____

| Score | Fitzpatrick Skin Type: |
|---|---|
| 0-7 | **I** (Always burns, extremely pale and Never tans, Red or blonde hair, light colored eyes) |
| 8-16 | **II** (Pale but somewhat tans and burns fairly easily) |
| 17-25 | **III** (Sometimes burns, mostly tans, has more of an "Light Olive" complexion) |
| 26-30 | **IV** (Rarely burns, almost always tans, has "dark olive" complexion) |
| Over 30 | **V** (Moderately pigmented (Indian,Hispanic,etc.) |
| | **VI** (African American) |

OLYMPIA AESTHETICS

# Warning Regarding HIPAA and Email/Text Communications

At Olympia Aesthetics your privacy and the security of your protected health information (PHI) are of utmost importance to us. AS a healthcare provider, we are committed to ensuring that your health information is handled with the highest level of care and in compliance with the Helath Insurance Portability and Accountability Act (HIPPA).

This letter serves as a warning and consent regarding the use of email and text message communications for transmitting and receiving PHI.

In our ongoing effort to enhance patient communication and convenience, we offer the option to communicate with you through email and text messages. However, it is important to understand the following:

1. **Security Risks**: Email and text messages are not completely secure methods of communication. While we take precautions to protect your information, there is a risk that these messages could be intercepted, accessed, or compromised by unauthorized individuals.
2. **Patient Responsibility**: It is your responsibility to ensure the security of your email and text message accounts. We recommend using strong, unique passwords and enabling two-factor authentication for you accounts.
3. **Consent**: By providing your consent below, you acknowledge and accept the potential risks associated with the use of email and text message for communication with Olympia Aesthetics regarding your PHI.
4. **Authorized Recipients**: We will make every effort to verify the identity of the recipient before sending any PHI via email or text message. Please respond promptly to any verification requests from Olympia Aesthetics.

Consent I, _____, understand the risks associated with email and text message communication for transmitting and receiving PHI. I hereby consent to receive email and text message communications from Olympia Aesthetics for the purpose of discussing my healthcare, appointments, and related matters. I acknowledge that I am responsible for maintaining the security of my email and text message accounts.

_____ _____

Signature Date

OLYMPIA AESTHETICS

# Refund Policy

At Olympia Aesthetics, we value your satisfaction and are committed to providing the highest quality services. Due to the nature of our services and the personalized care we offer, we do not provide refunds for services, products, or packages once they have been purchased. We are committed to addressing any concerns or issues promptly to ensure your experience with us is exceptional in every way.

_____ _____

Signature Date

OLYMPIA AESTHETICS

# NO SHOW/CANCELLATION POLICY

Due to high demand of service, all appointment No Shows and Same Day Cancellations, scheduled at Olympia Aesthetics will be charged a fee of $100. All cancellations must be done 24 hours prior to the scheduled appointment time to avoid this fee. We understand that health issues may arise, if this is to happen, we require that you provide a Doctors/Hospitalization note. By signing this document, you have acknowledged that you understand the service fee for No Show/Same Day Cancellations and authorize the credit card below or the card on file to be charged. Thank you for your understanding and cooperation.

[ ] Please use the card on file from scheduling my consultation appointment

Credit Card Type: ____ Visa ____ MasterCard ____ Discover ____ Amex Credit

Card Number: _____

Expiration Date: _____

Card Identification Number: Last 3 digits located on the back of the card (CCV):_____

_____ _____

Signature Date

OLYMPIA AESTHETICS

# Social Media Photography Consent Form

I, _____, hereby grant permission to Olympia Aesthetics, LLC, its employees, agents and affiliates, to take photographs and/or videos of me during my visit(s) to Olympia Aesthetics. These photographs and videos may be used for promotional and educational purposes on Olympia Aesthetics official social media accounts, website, marketing material and other related platforms. I understand and agree to the following:

1. **Purpose**: The purpose of these photographs and videos is to showcase the results of the services provided by Olympia Aesthetics, share educational content, and promote the services and expertise at Olympia Aesthetics.
2. **Confidentiality**: While Olympia Aesthetics will make reasonable efforts to maintain your privacy, I under that once images or videos are posted on social media, they may be accessible to a wide audience, and privacy cannot be guaranteed.
3. **No Compensation**: I will not receive any compensation, financial or otherwise, for the use of these photographs and videos.
4. **Duration**: This content shall remain in effect indefinitely unless I provide written notice to revoke it.

_____ _____

Signature Date

By signing this form, I acknowledge that I have read and understood the information provided and freely consent to the use of my photographs and videos for social media and promotional purposes by Olympia Aesthetics.

# Notice of Privacy Practices

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

## *USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION*

*Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.*

*Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.*

*Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.*

*Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.*

*Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:*

- *Reporting abuse of children, adults, or disabled persons.*
- *Investigations related to a missing child.*
- *Internal investigations and audits by the department's divisions, bureaus, and offices.*
- *Investigations and audits by the state's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability.*

- *Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals.*
- *District medical examiner investigations;*
- *Research approved by the department.*
- *Court orders, warrants, or subpoenas;*
- *Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.*

*Other uses and disclosures of your protected health information by the department will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to the Department of Health.*

*INDIVIDUAL RIGHTS*

*You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.*

*You have the right to be assured that your information will be kept confidential. The Department of Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.*

*You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.*

*You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:*

- *Was not created by the department.*
- *Is not protected health information.*
- *Is by law not available for your inspection.*
- *Is accurate and complete.*

*If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.*

*You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:*

- *Disclosures made to you.*
- *Disclosures to individuals involved with your care.*
- *Disclosures authorized by you.*
- *Disclosures made to carry out treatment, payment, and health care operations.*
- *Disclosures for public health.*
- *Disclosures to health professional regulatory purposes.*
- *Disclosures to report abuse of children, adults, or disabled.*
- *Disclosures prior to April 14, 2003.*

*This summary does include disclosures made for:*

- *Purposes of research, other than those you authorized in writing.*
- *Responses to court orders, subpoenas, or warrants.*

*You may request a summary for not more than a 6 year period from the date of your request.*

*If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.*

*The Department of Health may mail or call you with health care appointment reminders.*

### *Department of Health Duties*

*The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.*

*As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.*

*The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at www.myflorida.com and will be available by email and at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.*

### *Complaints*

*If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL*

*32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.*

*The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.*

### *For Further Information*

*Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.*

### *Effective Date*

*This Notice of Privacy Practices is effective beginning July 1, 2013, and shall be in effect until a new Notice of Privacy Practices is approved and posted.*

### *References*

*"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. Federal Register 65, no. 250 (December 28, 2000).*
*"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. Federal Register, Volume 67 (August 14, 2002).*

*HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).*

OLYMPIA AESTHETICS

# Authorization To Disclose Confidential Information

**INFORMATION MAY BE DISCLOSED BY:**

Person/Facility: _____ Phone: _____

Address: _____ Fax: _____

**INFORMATION MAY BE DISCLOSED TO:**

Person/Facility: _____ Phone: _____

Address: _____ Fax: _____

**METHOD OF DISCLOSURE:**

[ ] Pick up at Clinic/Facility

Address: _____
Fax #: _____

[ ] Email Address: _____

**(Please note that emailing may not be a secured method of communication)**

**INFORMATION TO BE DISCLOSED:** (**Initial** Selection)
[ ] Consultation Notes [ ] History and Physical Progress Notes

[ ] Photography [ ] All Records

**PURPOSE OF DISCLOSURE:**
[ ] Continuity of Care [ ] Personal Use

**EXPIRATION DATE:**
This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or even, this authorization will expire twelve (12) months from the date on which it was signed.
**REDISCLOSURE:** I understand that once the above information is disclosed, it may be disclosed by the recipient and the information my not be protected by federal privacy laws or regulations.
**CONDITIONING:** I understand that completing this authorization form is voluntary. I realize the treatment will not be denied if I refuse to sign this form.

**REVOCATION:** I understand that I have the right to revoke this authorization anytime. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

| | |
|---|---|
| Client/Legal Representative Signature | Date |
| Printed Name | Representative's Relationship to Client |

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to request this information (for example, power of attorney, healthcare surrogate form, order or appointment of a guardianship, order appointing personal representative and letters of administration).