AISLINN MEDICAL SPA

HIPAA CONSENT

Expiration Date

Consent to Use and Disclose Protected Health Information for Treatment, Payment, and Healthcare Operations

I understand that as part of my health care, Aislinn Medical spa originates and maintains records describing my health history, symptoms, examination, treatments and procedures, test results, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I Authorize Aislinn Medical Spa to disclose personal health information to the following people.

_____ _____

Name of Individual Relationship Name of Individual Relationship

I understand that I may request a ***Notice of Health Information Practices*** (that provides a more complete description of information uses and disclosures). I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Aislinn Medical Spa is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron. I understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Aislinn Medical Spa reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Aislinn Medical Spa change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail)

I wish to have the following **restrictions** to the use or disclosure of my protected health information other than those listed in Aislinn Medical Spa's Privacy Policy:

Restrictions: _____

I fully understand and accept the terms of these Privacy Consents

_____ _____ _____

Signature of Patient or Legal Guardian **Relationship to patient** **Today's Date**

_____ _____

Patients Name (written) **Date of Birth**