AUTHORIZED REPRESENTATIVE FORM – HIPAA

Note: This form is used to confirm a Patient's permission that the staff of the Aesthetic and Anti-Aging Medicine Center may discuss or disclose protected health information to a particular person who acts as their Authorized Representative.

You have the right to request that we restrict how Protected Health Information (PHI) about you is used or disclosed for treatment, payment, or health care operations.

Patient Information: By signing this form, you consent to our use and disclosure of PHI about you is used or disclosed for treatment, payment, or health care operations. I understand and agree that the Aesthetic and Anti-Aging Medicine Center may release my personal health information to my Authorized Representative(s).

Authorized Use and/or Disclosure:
I understand that the Aesthetic and Anti-Aging Medicine Center does not disclose my personal health information to other parties, except those directly involved in my care, without my written authorization. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my personal representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Patient Name- Print:_____
Patient Signature:_____ Date:_____
Relationship to Patient (if other than patient):_____

Witness (Staff): _____ Date: _____

Authorized HIPAA Representative #1:
Name:_____ Phone Number: _____
Address: _____
Relationship to patient: _____

Authorized HIPAARepresentative #2:
Name:_____ Phone Number: _____
Address: _____
Relationship to patient: _____