PATIENT AUTHORIZATION /RELEASE FORM

Patient Name: _____ Birth Date: _____/_____/____
MM / DD / YR

Address:

Home Telephone Number:

Patient Identification Number and/or Social Security Number:

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my health information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. ***Orchidia Medical Group may condition the provision of research-related treatment on the provision of an authorization to use and/or disclose an individual's health information for such research. If you wish to make such a condition, you must include a description of these circumstances.]***

1. I Authorize the Following Health Information to be Used and/or Disclosed.

ALL MEDICAL RECORDS

2. I Authorize the Following Persons/Organizations to Use and/or Disclose My Health Information.

Orchidia Medical Group and any physician, medical center, practitioner, agency or media (print/broadcast/film etc.) that we may use for the sole purpose of advertising or marketing the procedure that we are requesting from you.

3. I Authorize the Following Persons/Organizations to Receive and/or Use My Health Information.

Orchidia Medical Group and any physician, medical center, practitioner, agency or media (print/broadcast/film etc.) that we may use for the sole purpose of advertising or marketing the procedure that we are requesting from you.

4. I Authorize My Health Information to Be Used and/or Disclosed for the Following Purpose(s).

5. My Right to Revoke This Authorization. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing and sent to Orchida Medical Group – 2590 Golden State Parkway – Suite 104 Naples, FL 34105. I am aware that my revocation will not be effective if (i) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself or (ii) to the extent the person(s) and/or organization(s) identified above have already acted in reliance upon this authorization with a third party.

6. Redisclosure of My Health Information. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses that are subject to the federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

7. Disclosure of Direct or Indirect Remuneration Received By Any Person and/or Organization Authorized to Use and/or Disclose My Health Information. I understand that NO ONE outside of Orchidia Med Spa will be receiving direct or indirect remuneration in connection with the use and/or disclosure of my health information.

8. Expiration of Authorization. This authorization will be effective indefinately.

_____ _____/_____/_____
Patient Signature Date

If Patient is unable to sign, complete the following:
Patient is unable to sign because:

Name of Personal Representative and Relationship to Patient:

Authority of Personal Representative (*e.g.,* health care power of attorney, guardian, other statutory authorization):

Address:
Home Telephone Number: E-mail:
Work Telephone Number:

_____ _____/_____/_____
Signature of Personal Representative Date