HIPPA PRIVACY AND RELEASE OF INFORMATION AUTHORIZATION

I, _____ hereby authorize RESULTS MEDICAL AESTHETICS, its employees and agents, to use disclose protected health information (e.q. information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have the right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if its employees or agents have taken action on this authorization prior to receiving my written notice_ I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g. Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____

Printed Patient Name Date

_____

Patient Signature