# HIPAA-Health Insurance Portability and Accountability Act

**YOUR RIGHTS**: Under the Federal Health Insurance Portability and Accountability Act (HIPAA), you have the right to request restrictions on how we use or disclose your personal information for treatment, payment, or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your health care or the paying of your care.

**EFFECTIVE PERIOD:** This authorization for release of information will remain in effect for one year from original date of signing or until revocation in writing is received.

**ACCESS TO YOUR PERSONAL HEALTH INFORMATION**: You have the right to inspect and/or obtain a copy of your personal health information we maintain in your designated medical records. You must sign a release of medical records consent form to obtain these records. I understand this is not in relation to requesting medical records for me for another physician. There is a separate form that is filled out for that request which I can obtain by contacting ALLURA SKIN, LASER, and WELLNESS CLINIC.

**FAMILY, FRIENDS, AND PERSONAL REPRESENTATIVES**: With your written consent we may disclose to family members, close personal friends, or another person you identify your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best physical interest, we may disclose your personal health information without your written or verbal approval. We may also disclose your personal health information to the public or private entities to assist in disaster relief efforts.

Person(s)/organizations authorized to receive and use this information:

- ☐ Insurance Company (Please write the name of your insurance company and policy number):

  _____

- ☐ Pharmacy (release of name, date of birth, allergies only)

- ☐ Significant Other or Family Member: _____

**OTHER USES AND DISCLOSURE**: We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:
For public health activities (reporting of disease, injury, birth, death, or suspicion of child abuse, neglect, or domestic violence).
To government authority if we believe an individual is a victim of abuse, neglect or domestic violence.
For health oversight activities (for example-audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions).
For law enforcement purposes (for example-reporting wounds or injuries or for identifying or locating suspects, witnesses or missing persons).
To avert a serious threat to health or safety under certain circumstances.

For military activities if you are a member of the armed forces or an inmate or individual confined to a correctional institution.
For compliance with worker's compensation claims.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

We will adhere to all state and federal laws or regulations that provide protections to your privacy. We will only disclose AIDS/HIV related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by law.

Patient PRINTED Name: _____

Patient Signature: _____

Date of Birth: _____ Date: _____

Witness Signature: _____ Date: _____