HIPAA RELEASE AND AUTHORIZATION

Patient Name: *

Date of Birth *

MM/DD/YYYY

Phone # *

Home address *

Email *

Medical Records: I hereby authorize Cheeky Medspa to disclose the following: (check one) *

- ○ ALL Medical Records. I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (ePHI) protected under HIPAA. Be advised, this will not include any photos.
- ○ Specific Medical Records. Be advised, this will not include any photos.

Specific medical records to be released (please include service name, location service was received, and date parameters):

Purpose of Release: *

Recipient. My medical records shall be disclosed to the following individual or entity:

Recipient Name: *

Relationship to Recipient *

Phone *

Physical Address *

Email *

Format for Release (check one)- All printed records will incur a charge of $0.30 per page. *

- [ ] Paper - mailed (will be charged fee for this service). Not a HIPPA complaint option. This option will release all liability from Cheeky. We do not recommend this option as there is a certain amount of risk.
- [ ] Paper - pick up from Cheeky. Once the records leave Cheeky, we are release of all liabilities.
- [ ] Email (will be sent to recipient email listed above). Note: we do not have a HIPPA compliant email and this will be a risk to your sensitive information. No liability will be placed on Cheeky if you choose this route. We recommend picking up in person the printed versions.

Which Cheeky Medspa location are you wanting to pick up the records: *

- [ ] Kenai
- [ ] Homer
- [ ] Fairbanks

Expiration. This release of information authorization expires on: (can be no longer than 30 days)

MM/DD/YYYY

Please check the below boxes to confirm understanding of each statement. *

- [ ] I understand that signing this authorization is voluntary and that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon whether I sign this authorization.
- [ ] I understand that I have the right to revoke this authorization at any time by writing to the Releasor, except where uses or disclosures have already been made based upon my original permission.
- [ ] I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient is NOT protected by HIPAA.
- [ ] I will maintain a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

- [ ] I understand that it may take up to 60 business days to receive the copy of my records and that I may be financially responsible to cover the cost of printing and/or postage, and time of the staff to gather this information.

Signature *