West Linn Aesthetic Medicine

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) may include, but is not limited to: appointments - making/changing/reminders, treatment plan, follow up after cosmetic procedure, and any other information that West Linn Aesthetic Medicine may need to discuss regarding your healthcare r/t cosmetic treatments.

Patient Name:_____ DOB:_____
City and Zip code:_____

As required by the Privacy Laws, West Linn Aesthetic Medicine may not use or disclose your Protected Health Information without your authorization.

I hereby authorize West Linn Aesthetic Medicine & its employees to release to/or discuss info related to my cosmetic procedures/health with: (i.e. spouse, children, Dermatologist, plastic surgeon, etc…)

_____ _____
Name & Relationship to Patient Information that may be disclosed

OR ☐ **I Decline**

It is okay to contact me in the following manner regarding my PHI…

(Check/Write-in all that you agree to)

Primary Phone #:_____ ☐ **CELL** or ☐ **LANDLINE**

☐ **TEXT ok** ☐ **Voicemail Message ok**

☐ Voicemail message or text with *detailed information?*

OR

☐ Voicemail message or text with *name and call back number only*?

IF I CHOOSE TO COMMUNICATE VIA TEXT, I HEREBY PROMISE THAT I WILL NOT TEXT WHILE DRIVING A MOTOR VEHICLE ☐ **YES, I promise** or ☐ **NO, I choose not to text**

Email: _____ ☐ **HOME or** ☐ **WORK**

☐ Okay to discuss personal and/or detailed information via email? ☐ Not okay

_____ _____
Print name of Patient **Date**

_____ _____
Signature of Patient **Provider Initials**

TO CONTINUE TO KEEP YOUR HEALTH INFORMATION PRIVATE AND CONFIDENTIAL, PLEASE NOTIFY WEST LINN AESTHETIC MEDICINE IF ANY OF THIS INFORMATION CHANGES!