RejuvenationMD®
Aesthetic Skin Treatment & Wellness Center

Consent to Release Medical Information/Records

This form is for use when such authorization is required and complies with the Health Insurance portability and Accountability Act of 1996 (HIPAA) Privacy Standards

Patient Name: _____ Date of Birth: ____/____/____

I authorize RejuvenationMD, PLLC to disclose and release:

☐ **All of my health information**
☐ **My health information relating to the following condition: _____**
☐ **My health information covering the period from _____(date) to _____(date).**

This medical record may contain information about ***sexual transmitted diseases.***

☐ **I consent to have the above information released.**
☐ **I do not consent to have the above information released.**

Signature: _____ Date: ____/____/____

This medical record may contain information concerning ***HIV and/or AIDS diagnosis or treatment.***
Separate consent must be given to have this information released.

☐ **I consent to have the above information released.**
☐ **I do not consent to have the above information released.**

Signature: _____ Date: ____/____/____

RejuvenationMD, PLLC may disclose or release this health information to the following recipient:

Name (or title) and Organization: _____
Address: _____, City _____,
State _____, Zip _____

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. Further, I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand you may charge a fee in accordance with WAC 246-08-400 for the copying the records but will not charge for time spent locating the records. Postage rates may apply.

Signature of Patient: _____ Date: ____/____/____

INTERNAL USE ONLY:

Received On: ___/___/___ Completed by: _____ Number of Pages: _____
Signature/ID Verified: ☐ Yes ☐ No Date Released: ___/___/___