# ***HIPAA CONSENT***

Skin Spectrum is not authorized to disclose any of your information to anyone other than you without your prior written consent. Please carefully read the following, check the appropriate boxes and sign and date at the bottom

I _____ authorize

(Print your name)

_____to conduct any or all of the following on my behalf:

(Name of person(s) you wish to authorize)

☐ To request my payment history: Year(s) _____

☐ To schedule, cancel, and/or confirm my appointments.
(Skin Spectrum may need to disclose your treatment plan to adequately schedule.)

☐ To place prescription requests, as well as discuss any concerns or questions regarding any medications prescribed to me.

☐ To allow the purchase of any procedures or products related to my account.
(Please note that we may disclose billing information, as well as previous product or treatment purchases and recommendations given to you during office visits.)

☐ I do not authorize any other person other than myself .

***This authorization shall remain in effect until revoked in writing by the requesting individual.**

**Signature:_____Date:_____**

**Date of Birth:_____**