Disclosure Form for Family Members/Friends

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I, _____, _____, authorize the
Name Date of Birth

providers at Devenir Aesthetics to release/discuss my health and medical information with:

Name: _____Relationship_____

Date from/ to: _____ / _____

Name: _____Relationship_____

Date from/ to: _____ / _____

Health information to be disclosed (check all that apply)

▫ **My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment and billing, for all conditions) OR**

▫ **My complete health record, as above, with the exception of the following information (Initial what is not authorized)**

I **DO NOT** AUTHORIZE THE FOLLOWING INFORMATION TO BE SHARED:

_____ Drug and/or alcohol abuse treatment
_____ HIV (AIDS) testing/treatment
_____ Psychiatric
_____ Sexually transmitted disease

▫ **I authorize Devenir Aesthetics to leave messages and information on my phone answering system. Preferred Number_____**

I understand that I can revoke, update or change this form at any time in writing. The termination of this authorization to release Protected Health Information is effective on the date that the physician office receives it. It does not apply to any information released prior to the date of receipt of the written termination.

This authorization will expire in 1 year from the date signed.

PATIENT SIGNATURE: _____
DATE: _____

February 10, 2017