



**CLIENT INFORMATION CONSENT FORM**

I have read and fully understand Elle Med Spa’s Notice of Information Practices. I understand that Elle Med Spa may use or disclose my personal health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Elle Med Spa will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Elle Med Spa’s Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I hereby authorize one or all of the designated parties below to request and receive the release of any PHI regarding my treatment, payment or administrative operations related to treatment or payment. I understand that the identity of designated parties must be verified before the release of any information.

**Authorized Designees:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Signature of Client/Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date