

ESTHETIC BOUTIQUE MED SPA

HIPAA FORM

Patient Consent: Message and/or Appointment Reminders Per HIPAA Regulations

Today's Date _____

Patient Name: _____

DOB: _____

May we leave the following types of messages at your home, work, cell or personal email:

1. Office appointment reminders/changes YES NO
2. Payment requirements for upcoming appointments YES NO
3. When authorization, medical records, or other information is needed YES NO
4. Prescription refill information YES NO
5. Receive office emails to my personal email account YES NO

Acknowledgement of Receipt of Notice

Yes No

As required by the privacy regulation, I hereby acknowledge that I have received a current copy of the privacy notice. You can find a copy of HIPAA information and form at our website www.estheticboutiquemedspa.com under the office forms tab. I understand that it is my responsibility to read through the given information, make any requests and provide documentation that may protect my confidentiality within this practice Esthetic Boutique Med Spa with my authorization and consent to use and disclose my healthcare information for the purposes of treatment, payment and healthcare described in the privacy policies.

Signature _____ Date _____

My healthcare information may be shared with the following persons:

Name & relationship to patient Name & relationship to patient _____

No, my records may not be shared _____