Perfect Skin Laser Center

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Due to the new HIPPA laws that are now in effect, we must have your written authorization to release your medical information to a person other than yourself. Understand that your information may need to be discussed with your current physician or any other member of your physician's office and/or other medical facility in regards to the scheduling of procedures. Only the information needed to do this will be released. This release will be valid for one year from the date of signing.

1. Whom may we release your medical information to [if needed]:

\_\_\_\_\_Spouse \_\_\_\_\_\_ Physician - Name

\_\_\_\_\_Sibling \_\_\_\_\_\_ Attorney - Name

\_\_\_\_\_Parent \_\_\_\_\_\_ Other - Please indicate who other is:

\_\_\_\_\_Son and/or Daughter \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. May we send you any correspondence by means of mail/e-mail/text message/phone call?

YES/NO

3. May we leave a message on your answering machine confirming an appointment or following up on any procedures done in our office?

YES/NO

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form Revised July 2018