DISCLOSURE AUTHORIZATION FORM
FAMILY & FRIENDS

Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services ("**PHI**"). As required by the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), Grant Stevens, M.D., Inc., Marina Plastic Surgery Associates, The Institute, and Comprehensive Skin Care ("**Practice**") has provided a Notice of Privacy Practices describing how it may use and disclose PHI. It is important to understand that any uses or disclosures outside those circumstances described in the notice will be made **only with your written authorization including most disclosures to family members or friends**. This means we will not disclose information to a person despite their relationship with you unless you have specifically authorized them to receive such information. Therefore, this authorization must be completed to identify those individuals who will be permitted to receive information about your medical care.

AUTHORIZATION

I authorize the Practice to disclose my PHI to those individuals listed below (*specify name, relationship and contact information if applicable*):

Name	Relationship	Contact Number

The information that can be disclosed to the above named individuals includes:

☐ All PHI

☐ Only information relating to (*specify such as appointments, payment, etc.*):_____

_____

☐ Only information pertaining to the time period from:_____ to _____

☐ Other (*specify*):_____

This authorization will be in full force and effect for two years unless otherwise indicated below.

☐ Expiration Date:_____

The PHI is being disclosed for the following purpose (*write "at my request" if there is no specific purpose or you do not wish to specify the purpose*):

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practice's Privacy Officer. I understand that a revocation is not effective to the extent that the Practice has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that, except as otherwise provided in this authorization, the Practice may use or disclose my PHI in accordance with Practice's Notice of Privacy Practices.

I understand that PHI disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act or other applicable laws or regulations.

I understand that the Practice will not condition my treatment, payment or eligibility for benefits on whether I provide authorization for the requested use or disclosure except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating PHI for disclosure to a third party.

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) **DATE**

PRINTED NAME

PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)