

**In Accordance with Federal Government and Health Portability and
Accountability Act
Patient Consent to the Use and Disclosure of Health Information
for Treatment or Healthcare Operations**

Essex Medspa would like you to take a moment to read this disclosure thoroughly. Please remember this disclosure does not give us permission to send your protected health information to anyone unless they are part of your medical treatment. We regret to inform you that if you choose no to sign this disclosure, we will not be able to disclose any information that is pertinent to your medical treatment.

I understand that as part of my health care, Essex Medspa originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Essex Medspa is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Essex Medspa reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Essex Medspa change their notice, they will send a copy of any revised notice to the address I have provided.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this contract.

Patient's Signature _____ Date _____