AQUA
MEDICAL SPA

TOLL FREE: 877-231-3376

www.AquaMedicalSpa.com

MEDICAL RELEASE CONSENT

Patient Legal Name: _____ Birth Date: _____ Social Security No. _____

Patient Address _____ Telephone No. _____

City _____ State _____ Zip Code _____

For Disclosure Only

I hereby authorize _____
Physician and Practice Name

Address _____

Fax Number _____ Telephone Number _____

To disclose medical record information and/or protected health information of the patient listed above to:

Physician and Practice Name _____ Telephone Number _____

Address _____ Fax _____

Purpose: _____

Type of Access Requested :

- ☐ Copies of the record
- ☐ Inspection of the record
- ☐ Entire Record

Select Portions of Personal Health Information :

- ☐ Emergency Room
- ☐ History & Physical
- ☐ Consult Report
- ☐ Operative Report
- ☐ Lab
- ☐ Imaging / Radiology
- ☐ Demographics
- ☐ Progress Notes
- ☐ Medication Record
- ☐ Path Report
- ☐ Physician Orders
- ☐ Billing Records
- ☐ Other_____

Expiration : This authorization shall expire upon (check one) :

- ☐ Fulfillment of this request (according to HIPAA or State Regulations, whichever is shorter)
- ☐ Date _____

I acknowledge, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

Fee/changes will comply with all laws and regulations applicable to release of information.

I have read the above and authorize the disclosure of the protected health information as stated

Date _____ Signature of Patient/Responsible Party _____ Relationship to Patient _____

Address and telephone number of Requestor (if different from patient information) _____