

**Oasis HIPPA Consent Form**

I give Oasis Medspa my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care options like quality reviews. I give Oasis Medspa my consent to use or disclose my protected health information in order to obtain payment for services and/or product.

I have been informed that I may review Oasis Medspa’s Notice of Privacy Practices (for a more complete description on uses and disclosures) before signing this consent.

I understand that Oasis Medspa has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Oasis Medspa is not required to agree to the request. If Oasis Medspa agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient, Parent, Legal guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

If signed by representative, state relationship and sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_