



Please return completed form to Beauty Bus Foundation
via one of the following:
Mail: 11301 Olympic Blvd. #303, Los Angeles, CA 90064
Fax: 310-287-1271
Email: beauty@beautybus.org

HIPAA/CMIA Authorization

Name

Date of Birth

I am the Patient named above.

This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996, 42 USC Section 1320d et seq., and 45 CFR Parts 160 164, as amended from time to time (“HIPAA”), and/or any information governed by California’s Confidentiality of Medical Information Act, California Civil Code Section 56 et seq., as amended from time to time (“CMIA”). Specifically, this release authority complies with the valid authorization requirements of 45 CFR Section 164.508(c).

Pursuant to HIPAA and/or CMIA, I authorize and direct: Any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give, disclose, and release, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health

condition to the Beauty Bus Foundation and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives (“Beauty Bus”).

I understand that all medical information disclosed hereunder will be treated as confidential. The purpose of the use and disclosure of such medical information shall include determinations by Beauty Bus regarding whether I am an appropriate candidate to receive certain beauty treatments.

I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this Authorization, I must do so in writing. The procedure for how I may revoke this Authorization, as well as the exceptions to my right to revoke, will be performed in accordance with applicable federal law and any applicable policy of my health care provider.

I understand that I may refuse to sign this Authorization. I also understand that my health care provider cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility of benefits if I refuse to sign this Authorization.

The information that is disclosed pursuant to this Authorization may be re-disclosed by the person or agency that receives it without my authorization.

The authority given to the Beauty Bus shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. Such authority shall expire upon my death or in the event that I revoke the authority in writing and deliver it to my health care provider.

I have read and understand the information in this authorization form.

_____ Date: _____
(Signature)