

BEAUTY BUS AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION



Beauty Bus Foundation  
2716 Ocean Park Blvd., Suite 1062  
Santa Monica, CA 90405  
phone 310.392.0900 | fax 310.392.0907  
www.beautybus.org

**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

Name of patient: \_\_\_\_\_

***USE AND DISCLOSURE OF HEALTH INFORMATION***

I hereby authorize \_\_\_\_\_  
[Name of Doctor or practice]

to release to:

**BEAUTY BUS FOUNDATION, 2716 OCEAN PARK BLVD., SUITE 1062, SANTA MONICA, CA 90405**

the following information:

Any and all health information other than psychotherapy notes may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records, and/or HIV test results, if any, except as specifically provided below:

\_\_\_\_\_  
\_\_\_\_\_

***PURPOSE***

Purpose of requested use or disclosure:

Determination by Beauty Bus regarding whether I am an appropriate candidate to receive pampering products through the Bag of Beauty program

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**EXPIRATION:** This Authorization expires: December 31, 2025.

**MY RIGHTS**

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits, but it may affect my ability to obtain services from Beauty Bus.

I may inspect or obtain a copy of the health information of which I am being asked to allow the use or disclosure.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address [Physician’s address for notice]: \_\_\_\_\_

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not protected by California law and may no longer be protected by other state or federal confidentiality law (HIPAA).

**SIGNATURE**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

Signature: \_\_\_\_\_

***(patient/representative/spouse/financially responsible party)***

If signed by someone other than the patient, state your legal relationship to the patient:

Witness: \_\_\_\_\_

**Please return completed application form to Beauty Bus Foundation**  
**via one of the following:**  
**Mail: 2716 Ocean Park Blvd., Suite 1062**  
**Santa Monica, CA 90405**  
**Fax: 310-392-0907**  
**Email: [bagsofbeauty@beautybus.org](mailto:bagsofbeauty@beautybus.org)**