Mystique MEDICAL SPA
& Wellness Center of Fresno, Inc.

CLIENT INFORMATION CONSENT FORM

I have read and fully understand MYSTIQUE MEDICAL SPA'S Notice of Information Practices. I understand that MYSTIQUE MEDICAL SPA may use or disclose my personal health information (PHI) for the purposes of carrying out **treatment, obtaining payment, evaluating the quality of services** provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that MYSTIQUE MEDICAL SPA will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in MYSTIQUE MEDICAL SPA'S Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I hereby authorize one or all of the ***designated parties below to request and receive the release of any PHI*** regarding my treatment, payment or administrative operations related to treatment or payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____
Client Name

_____
Signature of Client/Guardian

_____/_____/_____
Date