OPTIMAL
HEALTH & SKIN
Face • Body • Wellness

Please complete this authorization and provide to us by one of the means below.
In person: 4701 Old Shepard Place, Suite 260, Plano, TX 75093
Email: support@optimalhealthandskin.com
Fax: 1.877.788.3131

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: Date of Birth:

Street Address:

City: State: Zip:

Phone:

I HEREBY AUTHORIZE OPTIMAL HEALTH & SKIN TO DISCLOSE MY INFORMATION TO THE PROVIDER NAMED BELOW.

ATTN/Provider Name: Phone:

I request that my information is shared via the method checked below:

❑ Fax and the fax number is: _____

❑ Email and the email address is: _____

❑ Mailing address and the address is: _____

Information to be disclosed:

❑ Procedures/Medications
❑ Physiological Evaluation
❑ Consultation Reports
❑ Progress Notes
❑ Supplementation
❑ Lab Work
❑ All information
❑ Other: _____

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken reliance on it.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose; confidentiality may be protected by federal law. If so, federal regulations prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as other wise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

DATE: PATIENT SIGNATURE:

WITNESS (Partent, Guardian or Authorized Representative):

WITNESS SIGNATURE: