



**PATIENT AUTHORIZATION TO RELEASE  
PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

By signing this, I authorize Laser Aesthetic Contouring of Idaho (L.A.C.I.) to use and/or disclose certain protected health information (PHI) about me to the party or parties listed below.

This authorization permits L.A.C.I. to use or disclose to \_\_\_\_\_ the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, etc.)

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When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Act.

Signed by: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_