BNG Aesthetics

Medical Spa and Laser Center
24 W. Fourth Street, Williamsport, PA 17701
Tel: (570) 748-6445 Fax: (570) 980-9138
Email: info@bngaesthetics.com
Website: www.bngaesthetics.com

HIPAA Authorization

In compliance with BNG Aesthetics Skin & Laser Center's privacy practices this form will allow you to designate an individual(s) to whom BNG Aesthetics Skin & Laser Center may disclose your protected health information. This may include individually identifiable information related to past, present or future appointment, medical or financial information. This does not include information relating to mental health treatment or HIV test results as releasing that information requires your separate written consent. If you do not want to designate an individual(s) to receive your protected health information, indicate "none" below.

Name: _____Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

I do hereby authorize BNG Aesthetics Skin & Laser Center to disclose protected health information to the following:

1. _____ _____ _____
   Name | Relationship to Patient | Telephone Number
2. _____ _____ _____
   Name | Relationship to Patient | Telephone Number
3. _____ _____ _____
   Name | Relationship to Patient | Telephone Number

By signing below I acknowledge that I have had full opportunity to read and consider the content of this authorization and understand that my protect health information may be disclosed to the individual(s) listed above. I understand that designating the individual(s) listed above does not exclude BNG Aesthetics Skin & Laser Center from disclosing my protected health information as outlined by BNG Aesthetics Skin & Laser Center privacy practice, (copy will be provided upon request).

I understand that I have the option to revoke this authorization at any time at which time I can execute a new authorization. I also understand that unless revoked in writing by completing a new authorization form, this authorization will remain in effect until I choose to revoke it.

Patient Signature: _____Date: _____

Witness Signature: _____Date: _____

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Photograph & Videotape Consent Form

I hereby authorize the taking of photographs and/or video by Dr. Boris Gabinskiy and any of his associates or representatives, with the full understanding that such photographs and/or video may be used for any/all of the items listed below.

This consent may be withdrawn by sending us a written request to remove. We cannot be responsible for any photos/videos that may have been reposted prior to your written request to withdraw this consent.

Please read and initial all that apply, and sign below to acknowledge your consent.

ADVERTISING PURPOSES (NEWSPAPERS/MAGAZINES, ETC.) _____

SHOWING OTHER PATIENTS IN THE OFFICE _____

DISPLAYING PHOTOS IN THE OFFICE _____

TELEVISION OR OTHER MEDIA _____

INTERNET, BNG WEBSITE _____

CANNOT BE USED FOR ANY OF THE ABOVE _____

OTHER (DESCRIPTION) _____

_____

Signature: _____ Date: _____

Printed Name: _____