KORU
Wellness Aesthetics NYC

PATIENT AUTHORIZATION / RELEASE FORM

Patient Name: _____ Birth Date: _____/_____/_____
MM / DD / YR

Address: _____

_____

Home Telephone Number: _____ E-mail: _____
Work Telephone Number: _____

Patient Identification Number and/or Social Security Number: _____

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my health information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. ***Koru Medical may condition the provision of research-related treatment on the provision of an authorization to use and/or disclose an individual's health information for such research. If you wish to make such a condition, you must include a description of these circumstances.***

1. I Authorize the Following Health Information to be Used and/or Disclosed:

_____

_____

2. I Authorize the Following Persons/Organizations to Use and/or Disclose My Health Information.

Koru Medical and any physician, medical center, practitioner, agency or media (print/broadcast/film etc.) that we may use for the sole purpose of advertising or marketing the procedure that we are requesting from you.

3. I Authorize the Following Persons/Organizations to Receive and/or Use My Health Information.

Koru Medical and any physician, medical center, practitioner, agency or media (print/broadcast/film etc.) that we may use for the sole purpose of advertising or marketing the procedure that we are requesting from you.

4. I Authorize My Health Information to Be Used and/or Disclosed for the Following Purpose(s).

_____

_____

Vivian Chin, MD, MPH
Medical Director
341 East 78th Street, New York, NY 10075
917-773-8878

5. My Right to Revoke This Authorization. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing and sent to Dr. Vivian Chin – 341 East 78th Street, New York, NY 10075. I am aware that my revocation will not be effective if (i) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself or (ii) to the extent the person(s) and/or organization(s) identified above have already acted in reliance upon this authorization.

6. Redisclosure of My Health Information. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses that are subject to the federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

7. Disclosure of Direct or Indirect Remuneration Received By Any Person and/or Organization Authorized to Use and/or Disclose My Health Information. I understand that NO ONE outside of Koru Medical will be receiving direct or indirect remuneration in connection with the use and/or disclosure of my health information.

8. Expiration of Authorization. This authorization will be effective indefinitely.

_____ _____/_____/_____
Patient Signature Date

If Patient is unable to sign, complete the following:
Patient is unable to sign because: _____

Name of Personal Representative and Relationship to Patient: _____

_____

Authority of Personal Representative (*e.g.,* health care power of attorney, guardian, other statutory authorization): _____

Address: _____

Home Telephone Number: _____ E-mail: _____
Work Telephone Number: _____

_____ _____/_____/_____
Signature of Personal Representative Date

Vivian Chin, MD, MPH
Medical Director
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