

# AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT PHOTOGRAPHIC AND/OR VIDEO IMAGES

## AUTHORIZATION:



I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

## PURPOSE:

The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising

## REVOCABILITY:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

## NO TREATMENT CONDITIONS:

I understand that the practice cannot condition treatment on whether or not I sign this authorization.

## IF DESIRED, COPY PROVIDED:

- "Yes, I would like a copy of this form."  
(initialed by team member, copy provided by )

( \_\_\_\_\_ )

**PRACTICE NAME:** \_\_\_\_\_

**PRACTICE NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

## IF PERSONAL REPRESENTATIVE

**NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_

## IF PATIENT IS A MINOR

**PARENT / LEGAL GUARDIAN:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

## FORM PROVIDED COURTESY OF:

This form is provided by My Social Practice for general convenience purposes and does not represent legal advice. Additional compliance rules vary from state to state, country to country. If you feel like you need legal consultation in addition to what we've provided, be sure to consult your practice attorney including seeking advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services regulations. My Social Practice is a social media marketing company. We are NOT attorneys, and although this form is based on our own research to ensure compliance, it does not represent legal advice.



# INDEMNITY FORM / CLIENT CONFIDENTIALITY FORM

Client Name: \_\_\_\_\_

Salon Name: \_\_\_\_\_

Please circle: Male / Female

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Previous discomfort, stinging and adverse reactions please tick:

<input type="checkbox"/> Skin Disorders	<input type="checkbox"/> Inflammation of the skin	<input type="checkbox"/> Eye disease
<input type="checkbox"/> Eye Infections	<input type="checkbox"/> Recent eye surgery	<input type="checkbox"/> Blepharitis
<input type="checkbox"/> Watery eyes	<input type="checkbox"/> Hayfever	<input type="checkbox"/> Allergies
<input type="checkbox"/> Bell's Palsy	<input type="checkbox"/> Previous reactions to eye treatments	<input type="checkbox"/> Contact lenses
<input type="checkbox"/> Allergies to latex/band aids	<input type="checkbox"/> Allergies to adhesives, glues or bonding agents	<input type="checkbox"/> Allergies to acetone
<input type="checkbox"/> Are you pregnant or lactating?	<input type="checkbox"/> Skin Disorders	<input type="checkbox"/> Are you taking HRT?

Any medications: \_\_\_\_\_

Other relevant information: \_\_\_\_\_

Have you had eyelash or brow tinting, eyelash perming, eyelash extensions or semi permanent mascara applied previously?

Please circle: NO / YES - which treatment?

TINTING  EYELASH PERM/LIFT  EYELASH EXTENSIONS  SEMI PERMANENT MASCARA

Did you experience any reaction to these treatments?

Please circle: NO / YES - which treatment?

TINTING  EYELASH PERM/LIFT  EYELASH EXTENSIONS  SEMI PERMANENT MASCARA

Please provide details of this reaction:

\_\_\_\_\_  
 \_\_\_\_\_

Did you seek medical advice from a doctor or specialist as a result of this reaction?

Please circle: NO / YES - what was the advice of your doctor/treatment given:

\_\_\_\_\_  
 \_\_\_\_\_

Agreement: I request and consent to these procedures being carried out today without undergoing a sensitivity patch test. The sensitivity test, which if conducted, may indicate my sensitivity / allergy to the products. I understand the contents of this form and take full responsibility for my actions, thus absolving all other parties of their responsibilities, if any, associated with the supply of the products and services(s).

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

BEAUTY PROFESSIONALS NOTES: \_\_\_\_\_

TREATMENT BEING PERFORMED: \_\_\_\_\_