**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I,_____ hereby authorize the use and or disclosure of my protected health information by Lane F. Smith, M.D., Smith Plastic Surgery, Inc., and Surgery Institute of Las Vegas, LLC, and Chic La Vie Medical Spa as described below and I understand the following:

In the case of my posting concerning my procedures or surgery on any social media websites such as Yelp, Facebook, Real Self, Google, WebMD etc. or pursuing legal action of any kind, or disputing payments or financial issues concerning my procedures or surgery, I hereby authorize the use of any and all protected health information, photos, or information concerning my treatment from Lane F. Smith, M.D., Smith Plastic Surgery, Inc., and Surgery Institute of Las Vegas, LLC, and Chic La Vie Medical Spa to be disclosed and no longer protected by State of Nevada and federal privacy regulations including but not limited to HIPAA Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

**NOTICE OF RIGHTS AND OTHER INFORMATION**

- I may refuse to sign this Authorization.
- I understand that the person or entity that receives the information may not be covered by the federal privacy regulations; in that case, the information described above may be redisclosed and no longer protected by these regulations. I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for the use and/or disclosure.
- I may cancel this authorization at any time. Cancellation of my authorization must be in writing, signed by me (or on my behalf), and delivered to Lane F. Smith, M.D., Smith Plastic Surgery, Inc., and Surgery Institute of Las Vegas, LLC. Cancellation of my authorization will be effective when Smith Plastic Surgery receives my signed request, but it will not apply to the information that was used or disclosed prior to that date.
- I have a right to receive a copy of this authorization. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

_____ DATE:_____

Signature of Patient

_____ DATE:_____

Signature of Legal Representative if applicable

_____ DATE:_____

Signature of Witness from Smith Plastic Surgery