elleebana
ONE SHOT LASH LIFT

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:

◯	Skin Disorders	◯	Inflammation of the skin	◯	Eye disease
◯	Eye Infections	◯	Recent eye surgery	◯	Blephartitis
◯	Watery eyes	◯	Hayfever	◯	Allergies
◯	Bell's Palsy	◯	Previous reactions to eye treatments	◯	Contact lenses
◯	Allergies to latex/band aids	◯	Allergies to adhesives, glues or bonding agents	◯	Allergies to acetone
◯	Are you pregnant or lactating?	◯	Skin Disorders	◯	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 theses 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 advise from a doctor or specialist as a result of this reaction?

Please circle: NO / YES – what was the advise 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: _____