Privacy Policy and Consent

PRIVACY POLICY OUTLINE AND CONSENT

Silk, A Medical Spa may collect personal health information about you directly from you and this personal health information may include, for example, your name, date of birth, address, email address, phone numbers, health history, records of your visits.
We may use and disclose your personal health information only to the extent necessary to:

- Treat and care for you
- Receive payment for your treatment and care (Credit Card information)
- Plan, administer and manage our internal operations
- Conduct quality improvement activities (such as sending patients satisfaction surveys) informational letters and coupon advertising
- Compile statistics (this excludes the use of names, addresses, phone numbers and email addresses)
- Comply with legal and regulatory requirements and fulfill other purposes permitted or required by law
- We take steps to protect your personal health information from theft, loss and unauthorized access, copying, modification, use, disclosure and disposal.
- We conduct audits and complete investigations to monitor and manage our privacy compliance.
- We take steps to ensure that everyone who performs services for us protects your privacy and only uses your personal health information for the purposes you have consented to.

I have reviewed SILK Medical Spa's Privacy Policy concerning the collection, use and disclosure of personal health information.

I understand that SILK Medical Spa is seeking my consent to collect, use and/or disclose my personal health information from me or from the person acting on my behalf for any or all of the purposes listed above.

I understand that I can refuse to sign this consent form and that I can withdraw my consent at any time by writing to SILK Medical Spa. I understand that refusal to sign this consent form or withdrawal of my consent may result in SILK Medical Spa refusing to provide services to me.

I hereby authorize SILK Medical Spa to collect, use and disclose my personal health information for the purposes listed above.

Patient or Person Authorized to Sign for Patient	Please Print Name Here
DATE	WITNESS