EXHIBIT 10
REVISED JANUARY 1, 2014

PATIENT AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION FOR PURPOSES OTHER THAN THOSE DISCLOSED IN THE NOTICE OF PRIVACY PRACTICES

LEAVITT MEDICAL ASSOCIATES OF FLORIDA, INC.

By signing this authorization, I authorize **Advanced Dermatology & Cosmetic Surgery** to use certain protected health information (PHI) about me for purposes of informing me of events, special offerings, skin care product and aesthetic services information that are appropriate for my skin type and condition or may be of interest to me.

In addition to those uses and disclosures delineated in our Notice of Privacy Practices, this authorization specifically permits us to use the following individually identifiable health information about me:
Diagnosis, Previous treatment records, Demographics, E-mail addresses and telephone number.

It has been explained to me that I do not have to sign this authorization in order to receive treatment from Advanced Dermatology & Cosmetic Surgery. In fact, I have the right to refuse to sign this authorization.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to **Privacy Officer, Leavitt Medical Associates of Florida, Inc., 151 Southhall Lane, Suite 300, Maitland, FL 32751.**

This authorization will expire on ________________________________
{Expiration Date or Defined Event}.

Signed by:

______________________________	______________________________
Patient's Name	Date
______________________________	______________________________
e-mail address	Print Name

PATIENT TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION