Skyhar MD, Inc

310 Santa Fe Drive, Suite 112, Encinitas, CA
760-690-3800

AUTHORIZATION TO RELEASE MEDICAL BILLING//PERSONAL MEDICAL INFORMATION

DATE ______/______/________

I, _________________________________ DO_____,DO **NOT**______ give

permission to Skyhar MD, Inc and staff to speak to _______________________//

_____________________________//_____________________________,

relationship(s):____ regarding my:

[ ] Medical Billing information
[ ] Personal Medical information

I am authorizing the release of the following information (check all that apply)

[ ] all records

[ ] all records except:____

[ ] only records related to:____

[ ] records of treatment from: ________________ to:_________________

[ ] sensitive information (substance abuse, psychiatric care, etc.)

This authorization is voluntary and may be revoked at any time by informing us in writing. I understand this authorization will expire:
Date___________________(not to exceed one year)

Patient Name______________________________ DOB____________________

Patient Signature____________________________ DATE:________________