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

HIPAA Authorization for use or disclosure of health information:

Patient Name: _____ Patient D.O.B:_____

Cell Phone: _____ Home Phone: _____

E-mail Address: _____

I authorize Skyhar MD, Inc. To leave messages with medical information on Voicemail/ Answering Machine/E-mail at: (Please check)

____ Home _____ Cell Phone _____ Work _____E-mail

I authorize for the following individual(s) to receive information pertaining to any medical history or treatment received:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

In accordance with Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office at (310 Santa Fe Drive, #112, Encinitas, CA 92024). My revocation will be effective once received by Skyhar MD, Inc.
2. The information provided under the release may be subject to re-disclosure by the recipient under circumstances no longer protected by HIPAA Privacy Rules.
3. My authorized representative will be required to provide legal documents to prove their authority to sign on my behalf and may be required to provide proof of identity.
4. A copy of this authorization may be used with the same effectiveness as the original.

This authorization shall supersede any prior written authorization I have made regarding the use, release and disclosure of my medical information. This authorization will expire 2 years from the date it is signed.

Signature: _____ Date: _____

OR Authorized Representative Name: _____ Relationship: _____

Authorized Representative Signature: _____ Date: _____