Sunnie Skiles, MD
6815 Five Star Blvd. #100
Rocklin, California 95677

P 916-626-3060
F 916-626-3063

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME/OTHER NAMES USED:____**DATE OF BIRTH**:___________________________________

PATIENT ADDRESS:____

I AUTHORIZE: **SUNNIE SKILES, M.D. PROYOUTH PEDIATRIC HEALTH & WELLNESS 6815 FIVE STAR BLVD. #100 ROCKLIN, CA 95677**

TO DISCLOSE TO: NAME____

ADDRESS____**PHONE**:___________________________**FAX**:_____________________

The following information contained in the records specified below (check box and initial applicable lines below):

___Mental health or developmental disability treatment records (excludes "Psychotherapy notes")

___Substance abuse treatment records

___HIV test results (This authorizes disclosure of laboratory test results only. **NOTE that your records may include information concerning your HIV status EVEN if you do not initial this line.**)

___The following records, please be specific with the types of health information, or records for the date(s) of treatment as specified:

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PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:

____At the request of the patient or personal representative; OR ____Other: ________________________________

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: _____________________

MY RIGHTS: I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits. I may revoke this authorization at any time, but I must do so in writing and submit it to the following: **Attn: Privacy Official 6815 Five Star Blvd #100, Rocklin, CA 95677**. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality las (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R part 2.

SIGNATURE:____**DATE**:_________________________

PRINT NAME OF PERSONAL REPRESENTATIVE:____

RELATIONSHIP TO PATIENT: ___________________________**Patient/Representative Address and phone**:_______________________________________

Note: If the substance abuse treatment information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.