

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



P 916-626-3060
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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME/OTHER NAMES USED: _____ **DATE OF BIRTH:** _____

PATIENT ADDRESS: _____

*****PLEASE PROVIDE PREVIOUS DOCTOR'S INFORMATION BELOW*****

I AUTHORIZE: **NAME:** _____

ADDRESS: _____ **PHONE:** _____ **FAX:** _____

TO DISCLOSE TO: **SUNNIE SKILES, M.D. PEDIATRIC HEALTH & WELLNESS**
6815 FIVE STAR BLVD. #100 ROCKLIN, CA 95677
PHONE: 916-626-3060 FAX: 916-626-3063

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:

VACCINE RECORDS COMPLETE MEDICAL RECORD

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 laws (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.