## HIPAA Privacy Authorization

(Required by the Health Insurance Portability
and Accountability Act, 45 C.F.R. Parts 160 & 164)

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I authorize SkyMedicus to use and disclose the protected health information described in this form.

Effective Period
- This authorization for release of information covers all past, present and future periods of healthcare from unless otherwise declared.

Extent of Authorization
- I authorize the release of my complete health records.

Acknowledgement
- I have read and fully understand the Terms of Service.
- I have read and fully understand the Privacy Policy.
- I have read and fully understand the Patient Rights and Responsibilities.
- I have read and fully understand the Assumption of Risk and Notice of Liability.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until we receive written notice.
Please mail to: SkyMedicus, 10080 Old Roswell Road, Suite 200, Alpharetta, GA 30009.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or other eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.