AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION As required by HIPAA, you have a right to request that communications concerning your personal health information be made through confidential channels. Periodically, we will need to contact you for appointment reminders, to give test results, or to speak with you regarding any insurance/billing concerns. Please assist us in providing the proper means to contact you, and if you are not available, the name(s) of those you give permission to speak to.

I hereby authorize SCKE-Odyssey Medical Group to leave detailed messages regarding my personal health information via:

Home Telephone Number Cell Phone Number	Yes / No Yes / No	Phone # Phone #		
Written (mailed) Communica To another address only Other address:	tion to my home	address on file	Yes / No Yes / No	
I also hereby request and au medical information relating to concerning myself to the indichildren, friends, etc.). I undewriting or by telephone. (Writ anyone to have access to yo in writing.	to diagnoses, ca viduals listed be erstand informat be "None" in the	are, treatment, test clow. (This may inc ion may be either of space provided be	results and prognos lude spouses, relation obtained in person, i low if you do not wa	sis ves, n nt
Name	Relat	ionship	Phone	
atient Name (Printed)		Legal Guardian Name (if applicable)		
Signature of Patient		Signature of Legal Guardian (if applicable		
Date	_	 Date	 	