For Office Use Only

Faxed To:

Date:

HIPAA Privacy Authorization Form

\*\*Authorization for Use or Disclosure of Protected Health Information

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

**\*\*1. Authorization\*\***

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (healthcare provider) to use and disclose the protected

health information for my **CHILD**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/**DOB:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

described below to: **BERNSTEIN PEDIATRICS**

**2121 E. Flamingo Rd. #100**

**Las Vegas, NV 89119**

**Ofc:(702) 796-7000**

**Fax: (702)796-9392**

**\*\*2. Effective Period\*\***

This authorization for release of information covers the period of healthcare from:

**□ All past, present, and future**.

**\*\*3. Extent of Authorization\*\***

***I authorize the release of:*** **□ All Health Records (Inc: Labs, X-ray Reports, Specialists)**

**□ Vaccines Record**

**□ Communicable diseases (Inc: HIV and AIDS)**

**□ Alcohol/drug abuse treatment**

**□ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4.** 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.

**5.** This authorization shall be in force and effect until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date), at which time this authorization expires.

**6.** 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 or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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

**8.** 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.

**Signature of Patient/Guardian:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Print Personal Representative/Relationship to Patient**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**