

WHOLE CHILD PEDIATRICS, P.C.

HIIAA 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 WHOLE CHILD PEDIATRICS, P.C. to use and disclose the protected health information concerning my child, [ ] to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (individual seeking the information.

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

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

a. □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\*\* or \*\*

b. □ all past, present and future periods.

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

a. □ I authorize the release of my child’s complete health records relating to mental healthcare, communicable diseases, HIV or AIDS, and the consequence of treatment of alcohol or drug abuse).

\*\* or \*\*

b. □ I authorize the release of my child’s complete health record with the exception of the following information:

 □ Mental health records

 □ Communicable diseases (including HIV and AIDS)

 □ The consequence of alcohol/drug abuse treatment

 □ other (please specifiy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. This medical information may be used by the person I authorize to receive this information for my child’s 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 or event), 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.

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Signature of parent or personal representative

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Printed name of parent or personal representative and his or her relationship to patient.

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Date