HIPPA 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 160-164)

1. Authorization

I authorize ________________________ (healthcare provider) to use and disclose the protected health information described below to _______________________________ (individual seeking 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 complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
OR
B. (   ) I authorize the release of my complete health record with exception to the following information:
(   ) Mental Health Records (   ) Communicable Diseases (includes HIV & AIDS)
(   ) Alcohol/Drug Abuse   (   ) Other (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, 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.

I have received a copy of the HIPPA Privacy Authorization Form from Kid's Therapy Unlimited, Inc.

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Signature of Patient or Personal Representative

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Printed Name of Patient or Personal Representative

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Date