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## 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)*

I authorize ..... *(healthcare provider)* to use and disclose  
the protected health information described below to  
**SOUTH ORLANDO PEDIATRICS** *(individual seeking the information)*  
.....

This authorization for release of information covers the period of healthcare

All records or  Labs  Immunization  X-ray  ER visit  Newborn discharge

- a. 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.
- b. This authorization shall be in force and effect until ..... *(date or event)*, at which  
time this authorization expires.
- c. 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.
- d. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be  
conditioned on whether I sign this authorization.
- e. 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.

**Patient's name** ..... **DOB** .....

**Signature of representative** ..... **Date** .....

**Printed name of Representative** .....

**Relationship to patient** .....