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:_____

_____/_____
Print Personal Representative/Relationship to Patient

Date: _____