PRINCETON NASSAU
PEDIATRICS
general pediatrics adolescent medicine

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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)

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:

☐ All past, present and future periods

-OR-

☐ _____ to _____

3. EXTENT OF AUTHORIZATION

☐ a. I authorized the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and the treatment of alcohol or drug abuse).

-OR-

☐ b. I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including 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. 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.

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

7. 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 or personal representative

_____
Printed name of patient or personal representative and his/her relationship to patient

_____
Date