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 _____ (occupational/physical therapist) to use and disclose my child's protected health information described below to SMILE Center, 2020 SW 5th Street, Lincoln, NE.

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**

   I authorize the release of my child's health record as it relates to the need of modifications for a child's ride-on car.

4. This medical information may be used by the person I authorize to receive this information for 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 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.

_____

Name of child

_____

Signature of personal representative

_____

Printed name of personal representative and relationship to child

_____

Date