HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____, 20____

I. **THE PATIENT**. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

i. Patient's Name: _____
ii. Date of Birth: _____, 20____
iii. Social Security Number: _____-____-_____

II. **AUTHORIZATION**. I authorize _**LOOKING AHEAD PEDIATRIC PT**___ ("Authorized Party") to use or disclose the following:

i. Patient Medical related information, including but not limited to Progress notes, evaluations, daily notes, measurements, etc. (Hereinafter known as the "Medical Records.")

III. **DISCLOSURE**. The Authorized Party has my authorization to disclose Medical Records to:

i. Any party that is approved by the Authorized Party. Including but not limited to TEIS, Orthopedic Medicine, Neurology, Ophthalmology, Chiropractic, other therapeutic agencies, etc.

IV. IV. **TERMINATION**. This authorization will terminate: (check one)

i. ☐ - Upon sending a written revocation to the Authorization Party.
ii. ☐ - Other: _____.

V. **ACKNOWLEDGMENT OF RIGHTS**.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

Looking Ahead PEDIATRIC PHYSICAL THERAPY PLLC
Excellence in Infant Head & Neck Disorders

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Patient Name _____

Parent Name: _____

Parent Signature: _____ Date: _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Other: _____