HIPAA Authorization Form
Authorization for Use or Disclosure of Protected Health Information

Today's date: Month _____ Day _____Year _____

TO:

JERCINOVIC PEDIATRICS, LTD 611 W. Jefferson St., Shorewood, IL

Patient's Name: _____ Date of birth: _____

I authorize my physician and/or administrative and clinical staff to (check all that apply):

____ use the following protected health information, and/or

____ disclose the following protected health information to:

Dr.: _____

Health Care Facility: _____

Other entity: _____

Address: _____City _____ State _____ Zip _____

Specifically and meaningfully describe the protected health information to be used or disclosed.

	Date
All Medical records	From_____To_____
Medical records pertaining to certain condition/illness (Please specify)	
_____	From _____To _____
Immunization records only.	From _____To _____
Billing and insurance records	From _____To _____
All records	From _____To _____

This protected health information is being used or disclosed for the following purposes:

This authorization shall be in force and effect until one month from requested date at which time this authorization to use or disclose this protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at 611 West Jefferson St. Shorewood, IL 60404. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
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.
My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Signature of Patient or Personal Representative

_____ Date _____

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority