HIPAA AUTHORIZATION FORM

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Harvest Pediatrics to use and/or disclose certain protected health information about me to insurance carriers, other physicians, or agencies to whom a referral for care may be made.

This Authorization permits Harvest Pediatrics to use and/or disclose the following individually identifiable health information about me, including but not limited to, dates of services, types of services and diagnosis rendered.

I acknowledge that by signing I authorize Harvest Pediatrics to receive payment from a third party (insurance) in exchange for using or disclosing the Protected Health Information.

I do not have to sign this Authorization to receive treatment from Harvest Pediatrics. I have the right to refuse to sign this Authorization. When my information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this Authorization. My written revocation must be submitted to the **Privacy Officer at Harvest Pediatrics.**

I also acknowledge that by signing, I authorize **Harvest Pediatrics** to leave Protected Health Information on a secured voicemail, i.e., lab results and appointment confirmation calls.

_____
Signature of Patient or Legal Guardian

Relationship to Patient _____
Patient Name: _____ **Date of birth:** _____