



## HIPAA Privacy Authorization Form

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

### AUTHORIZATION

I authorize EXCEL PRESCHOOL to **use, disclose** and **exchange** the protected health information described below with

\_\_\_\_\_ (individual/entity seeking or holding the information).

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Behavioral Records                        | <input type="checkbox"/> Diagnostic/Assessment/Progress Reports                    | <input type="checkbox"/> Direct Observations |
| <input type="checkbox"/> Individualized Education Plan (IEP)       | <input type="checkbox"/> Medical Records (i.e. wellness check, immunizations etc.) |  |
| <input type="checkbox"/> Individualized Family Service Plan (IFSP) | <input type="checkbox"/> Other _____   |  |

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.

This authorization shall be in force and effect until services are terminated. At which time, this authorization expires.

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.

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.

\_\_\_\_\_  
Printed- Child Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Authorized Signature

Relation to client (circle one of the following):

**MOTHER    FATHER    LEGAL GAURDIAN**

**other** \_\_\_\_\_

\_\_\_\_\_  
Date