# 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 ***PICTURE PERFECT ULTRASOUND*** (healthcare provider) to use and disclose the protected health information described below to _____
   _____
   _____

2. **Effective Period**
   This authorization for release of information covers the period of healthcare from:

   _____ to _____.

3. **Extent of Authorization**
   I authorize the release of my ultrasound records [including any physician reports, images, technical information and any other medical history on file]

4. 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.

5. This authorization shall be in force and in effect for the time frame noted above in #2.

6. I understand that I have the right to revoke this authorization, in writing or verbally, 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 my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

_____

**Signature of patient or personal representative**

_____

**Printed name of patient or personal representative**

**Date:** _____