KELLUM MEDICAL GROUP, PA

Family Practice * Pediatrics * Lifelong wellness

PLEASE PRINT CLEARLY

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability & Accountability Act-45 CFR Parts 160 & 164)

Authorization for release of PHI covering the period of health care of all past, present and future periods.

I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes I may direct.

- **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 claim.**
- **I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.**

_____

Patient or Parent Signature Date

_____

Printed Name Date of Birth