

**Ambassador South Inc.**  
3135 South Ocean Drive  
Hallandale Beach, Florida 33009

**HIPAA Privacy Authorization Form**  
**(Service Animal)**

I. Authorization\*

I authorize \_\_\_\_\_  
(healthcare provider) to use and disclose the protected health information  
described below to an Ambassador South Board Member.

II. Effective Period\*

Authorization expires three (3) months from the date of signature below.

III. Extent of Authorization\*

I authorize the release and confirmation of the medical necessity of a  
service animal, including the treatment plan and extent of the involvement  
of the service animal.

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

Signature of Patient or Legal Representative: \_\_\_\_\_

Name of Patient or Legal Representative: \_\_\_\_\_

Relationship to Patient (if not patient): \_\_\_\_\_

Date: \_\_\_\_\_