

# Genesis Pediatrics, LLC

## Patient Authorization for Practice to Release Protected Health Information

By signing this authorization, I authorize Genesis Pediatrics, LLC to use and/or disclose certain protected health information (PHI) about me as described below.

This authorization permits Genesis Pediatrics, LLC to use or disclose to (Specify person(s) or entity to receive the information and address) \_\_\_\_\_

the following individually identifiable health information(Check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Immunizations                    | <input type="checkbox"/> Laboratory Test/Results |
| <input type="checkbox"/> Progress Notes/Health Appraisals | <input type="checkbox"/> Radiology Test/Results  |
| <input type="checkbox"/> Medications                      | <input type="checkbox"/> Appointment History     |
| <input type="checkbox"/> Referrals/Consultations          | Other _____                                      |

This request may include disclosure of information relating to ALCOHOL/DRUG TREATMENT, MENTAL HEALTH INFORMATION, and CONFIDENTIAL HIV-RELATED INFORMATION only if Patient's/Legal Guardian's initials are included next to the desired information below.

Alcohol/Drug Treatment     Mental Health Information     HIV-Related Information

This protected health information is being used or disclosed for the following purpose (list specific purposes)

At patient's request with no specific purpose

Other \_\_\_\_\_

This authorization shall be in force and effect until the following date/event, at which time this authorization to use or disclose the protected health information expires.

This authorization is valid for the entire academic school year 20\_\_ - 20\_\_

This authorization shall expire on \_\_\_\_/\_\_\_\_/\_\_\_\_

This authorization shall expire after the follow event \_\_\_\_\_

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 in writing except to the extent that Genesis Pediatrics, LLC has acted in reliance upon this authorization. My written revocation must be submitted to Genesis Pediatrics', LLC HIPAA Manager at 900 Elmgrove Road, Rochester, New York 14624.

Signed by: \_\_\_\_\_  
Signature of Patient or Parent/Legal Guardian

\_\_\_\_\_  
Print Name of Patient or Parent/Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date