

# Genesis Pediatrics, LLC

## Patient Authorization for Practice to Release Protected Health Information

By signing this Authorization, I authorize Genesis Pediatrics, LLC to obtain and/or disclose certain protected health information (PHI) about me as identified below. **(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

The identified information may be obtained and/or disclosed from and/or to the following entities (individual(s) or organization(s) information may be shared with).

Entity \_\_\_\_\_ Address \_\_\_\_\_  
Entity \_\_\_\_\_ Address \_\_\_\_\_  
Entity \_\_\_\_\_ Address \_\_\_\_\_

The identified PHI is being obtained 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 obtain 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.

\_\_\_\_\_  
**Print Patient Name**

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

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date Signed**