Genesis Pediatrics, LLC

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In New York, patients over the age of 18 are no longer considered minors under the law. Under HIPAA this entitles you to the privacy of your individual health information. Therefore, as an individual you must review our Notice of Privacy Practices and complete the Acknowledgement form. Also as you are no longer considered a minor your parents/legal guardian **may not act** on your behalf **without** your authorization. This can make it difficult to gain all the access to care you may need, so you may choose to authorize others to act on your behalf. By completing the attached Authorization form you can appoint someone to have access to the information that you select.

If you have any questions regarding this notice or our health information privacy policies, please contact Richard P. Maniace, CPNP / HIPAA Manager, 900 Elmgrove Road, Rochester, New York 14624.

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):**

_____ Immunizations
_____ Progress Notes/Health Appraisals
_____ Medications
_____ Referrals/Consultations
_____ Laboratory Test/Results
_____ Radiology Test/Results
_____ Appointment History
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.

Signed by:

______________________________ Signature of Patient or Parent/Legal Guardian

______________________________ Print Name of Patient or Parent/Legal Guardian

______________________________ Patient's Name

______________________________ Relationship to Patient

______________________________ Date

GENESIS PEDIATRICS, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Genesis Pediatrics.

______________________________	______________________________
Printed Name of Parent / Patient (if 18 and older)	Signature of Parent / Patient (if 18 and older)
______________________________	______________________________
Date	Relationship to Patient

Please list name(s) of patient(s) and date of birth

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