Authorization for Genesis Pediatrics, LLC to Release Protected Health Information to Third Parties

(Schools, Daycares, Sport Leagues Etc.)

By signing this Authorization, I authorize Genesis Pediatrics, LLC to disclose certain protected health information (PHI) as identified below. (Check all that would apply). **** If you would like to decline; please indicate that by initialing here and then sign and date the bottom of the page.*** _____

_____ Immunizations
_____ Progress Notes/Health Appraisals
_____ Medications (Including Permission Notes)
_____ Referrals/Consultations
_____ Laboratory Test/Results
_____ Radiology Tests/Results
_____ Appointment History
_____ Other Information _____

This identified information may be released to the following organization(s) for the children I have indicated at my request to maintain enrollment or provide treatment while in their care. This Authorization shall be in force and effect for 12 months, expiring 1 year from date signed.

Organization _____ Child(ren) _____

Organization _____ Child(ren) _____

Organization _____ Child(ren) _____

Organization _____ Child(ren) _____

Request for information on ALCOHOL/DRUG TREATMENT, MENTAL HEALTH INFORMATION, or CONFIDENTIAL HIV-RELATED INFORMATION requires a separate Authorization to Release Information Form. (If you require these types of information to be released please ask the receptionists for the appropriate form).

When my information is 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.

Parent/Legal Guardian Signature: _____ Date: _____