# 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 indentified 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.

________________________________________
**Print Patient Name**

________________________________________
**Date of Birth**

________________________________________
**Signature of Patient**

________________________________________
**Date Signed**