Genesis Pediatrics, LLC
Request for Release of Medical Records

Reason for request: _____Transfer Medical Records _____Inspect Medical Records _____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.

Initial for: _____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information
(Requires completion of attached form)

Patient Name(s): _____ Date(s) of Birth: _____

_____ _____

Patient Address: _____Phone Number _____
Street

_____
City, State Zip

My children's medical records are to be transferred to: _____
Physician Name

_____ _____
Phone Number Address

_____ _____
Fax Number City, State Zip

Reason for Transfer_____

We recommend a summary medical record be created which includes: growth charts, immunizations, allergies, current medication list, labs, x-rays, specialist reports of last 12 months, most recent physical, and the last 3 office visits. A processing fee will be calculated at the rate of $0.75 per page up to a maximum of $10 per patient. Charge may be waived for patients aging out of pediatrics and transferring records directly to an adult physician. **Request will be processed and faxed once payment is received**; please contact the office to make payment arrangements. Please allow 7-10 business days to process.
(Copies of a complete record are available upon request subject to processing fees. Processing fee will be calculated at the rate of $0.75 per page with a maximum of $50.00 per patient)

_____ _____
Signature of Patient/Legal Guardian Date

_____
Print Name of Patient/Legal Guardian

FOR INTERNAL PURPOSES ONLY:

Received: Date_____ INIT _____ **Balance?** _____ PCP _____ Acct # _____

Pages _____ Amount Paid _____ Delivered By: Fax P/U Date_____ INIT_____

Processed: Date_____ INIT _____ Family Contacted: Date:_____ INIT_____

Pulled paper file _____ Patient Transfer Log _____ Chg patient/family status _____ Triaged billing _____

Records will be picked up: _____ Yes _____ No Name to be picked up by: _____

Sign at time of pick-up: Printed Name:_____ **Signature:** _____

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

New York State Dept of Health

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

( ) My HIV-related information
( ) Both (non-HIV medical and HIV-related information)
( ) My non-HIV medical information

Information below must be completed.

Name and address of facility/person disclosing HIV-related and/or medical information:

Genesis Pediatrics, LLC 900 Elmgrove Road, Rochester, NY 14624

Name of person whose information will be released:_____

Name and address of person signing this form (if other than above):_____

_____

Relationship to person whose information will be released:_____

Describe information to be released:_____

Reason for release of information:_____

Time Period During Which Release of Information is Authorized From:_____ To:_____

Disclosures cannot be revoked, once made. Additional exceptions to the right to revoke consent, if any:_____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):_____

All facilities/persons listed on pages 1,2 (and 3 if used) of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize.

Signature: _____ **Date:**_____

Complete information for each facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

1) Name and address of facility/person to be given general medical and/or HIV-related information:
_____
_____
_____

Reason for release, if other than stated on page 1:
_____

If information to be disclosed to this facility/person is limited, please specify:
_____
_____

2) Name and address of facility/person to be given general medical and/or HIV-related information:
_____
_____
_____

Reason for release, if other than stated on page 1:
_____

If information to be disclosed to this facility/person is limited, please specify:
_____
_____

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at **1-800-523-2437** or (212) 480-2522 or the New York City Commission on Human Rights at **(212) 306-7500**. These agencies are responsible for protecting your rights.
My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release medical and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

_____
Print Name

Client/Patient
Number_____