Genesis Pediatrics, LLC

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Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	**Date of Birth**
Patient Address	
Home Phone	**Cell Phone**

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and confidential HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release Information:

6. Name, Address, and Fax Number of Person(s) to Whom this Information Will be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from_____
INSERT START DATE

until_____
INSERT EXPIRATION DATE OR EVENT

☐ **All health information (written and oral), except:** _____

For the following to be included, indicate the specific information to be disclosed and initial below:

	Information to be Disclosed	**Initials**
Records from alcohol/drug treatment programs		
Clinical records from mental health programs		
HIV/AIDS-related information		

We recommend a summary medical record be created which includes growth charts, immunizations, allergies, current medication list, labs, x-rays, specialist reports of the last 12 months, most recent physical, and the last three office visits. Please allow 7-10 business days to process.

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____ _____

Signature of Patient/ Legal Guardian **Print Name of Patient/Legal Guardian** **Date**