Brighton Hill Pediatrics
151 Intrepid Lane, Syracuse, NY 13205
Phone (315) 469-8191 Fax (315) 469-4482

Consent to Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

(please print name)

1) I **AUTHORIZE** Brighton Hill Pediatrics to discuss my health information with:

_____ _____

Name of person(s) Relationship to patient

By signing this document I am consenting to disclosure of the following information: (PLEASE INITIAL ALL THAT APPLY)

___ HIV-related information ___ Non-HIV medical information ___ BOTH HIV related and Non-HIV medical information

___ Mental Health ___ Alcohol/Drug Use/Treatment

Please check one:

____ ALL records for the above initialed may be disclosed

____ Records for the above initialed may be disclosed for these dates only FROM ____/____/____ TO ____/____/____

OR

2) I **DECLINE** to give anyone permission to have access to my (and/or my children's) information. (initials) _____

The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the protected health information. I do not have to sign this authorization in order to receive treatment from Brighton Hill Pediatrics. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPPAA Privacy Rule. Brighton Hill Pediatrics, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer.

***Request for minor:** (under age 18) should be signed by the parent having legal custody or by the legal guardian; except in situations protecting the minor's privacy as stated by NY State Health Code regulations. As a minor in New York State you may seek treatment for certain conditions without knowledge or consent of his/her parents. In alcohol or drug abuse cases, HIV/AIDS, venereal disease or certain other contagious diseases, pregnancy, or family planning and abortion, only the minor may have access to the medical records unless he/she specifically gives consent for his/her parents or guardian to obtain information (see #2 DECLINE).

Authorization will expire on patients 21st birthday unless noted here with specific event or date: _____.

Date: ____/____/____ Patient Signature: _____ (if patient is 18 years or older)

Date: ____/____/____ Legal Representative: _____ (see request for minor*)