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

Authorization for the Release of Protected Health Information

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

(PLEASE PRINT NAME) **Phone Number**: ( ) -

Persons/Organization Providing the Information:

Name: Brighton Hill Pediatrics
Address: 151 Intrepid Lane
Syracuse, NY 13205

Persons/Organization Receiving the Information:

Name: _____
Address: _____
_____

Reason for Release of Protected Health Information: (PLEASE CHECK ONE)

Transfer of Care ____ Coordination of Care ____ Patient Request ____ Legal Proceedings ____

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

A. ____ HIV-related information B. ____ Non-HIV medical information C. ____ BOTH HIV related and Non-HIV medical information

D. _____ Mental Health E. _____ Alcohol/Drug Use/Treatment

Please note: your child's new born screening is considered "HIV related information" and cannot be forwarded without your initials on item A. or C. This authorization may include disclosure of HIV, alcohol and/ or drug abuse, and mental health treatment ONLY if your initials are placed on the lines to the left of A,C,D & E listed above.

In the event the health record includes the types of information described above, and I initial, I authorize release of such information to the person(s) indicated above. Confidential HIV related information is any information indicating that a person had HIV related test or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV. If I am authorizing the release of HIV related, alcohol and drug treatment, or mental health information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under Federal or State Law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release of disclosure of HIV related information, I may contact the New York State Division of Human Rights at (212) 480-2493, who is responsible for protecting my rights.

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.

Please allow up to 4 weeks for this Release of Protected Health Information to be processed.

Authorization will expire 12 months from the date this form is signed, unless noted here: _____

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

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