ADOLESCENT HIPAA CONSENT AUTHPRIZATION TO SHARE LABS/ RECORDS

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I, _____, give my permission for physicians at

PEDIATRICS EAST OF NEW YORK, P.C. to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give Pediatrics East or New York permission to:

Tick as appropriate

_____ Disclose a specific health record _____

_____Disclose my complete health record including, but not limited to, diagnoses,

lab test results, treatment, and billing records for all conditions.

Form of Disclosure:

_____Hard copy _____Verbal

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'

_____

_____

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: _____Phone#_____

Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by

state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid: Tick as appropriate

a) From _____ to _____

Or

b) The date of the signature in section VI until the following event: 6 months (please initial____)

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Pediatrics East Of New York, PC 1015 Madison Ave, Ste 502, NYC NY 10075

I understand that:

_____ In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.

_____I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

_____ I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signature: _____ Date: _____

Print your name: _____

Phone Number_____

Email Address_____

If this form is being completed by a person with legal authority to act an individual's behalf,

such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____

_____