MONROE COUNTY DEPARTMENT OF PUBLIC HEALTH
COMMUNICABLE DISEASE PREVENTION AND CONTROL DIVISION (CDPC)
STARLIGHT PEDIATRICS

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ____ **DOB:** ____

For the person named above, I authorize the release of the Protected Health Information maintained by:

STARLIGHT Pediatrics, 451 East Henrietta Road, 2nd Floor, Rochester, New York 14620-4629

My health information may be released under this authorization to:

Name: ____
(Include name of provider and, if known, name of practice)

Address: ____
(Street, City, State, Zip)

Only the following PHI may be released by this authorization *(check one box only)*:

☐ Diagnosis and treatment records for the duration of care at Foster Care Pediatrics, including medication history and immunization history.
☐ Only the following specific PHI is to be disclosed: ____

____

The purpose for which this information is to be disclosed is:

☐ Change of medical provider ☐ Patient/parent/legal guardian requested
☐ Information needed for care by specialist ☐ Purpose not disclosed
☐ Other (please specify): ____

I understand that:

- The facility cannot guarantee that the recipient of the Protected Health Information will not re-disclose the information to a third party, especially if the recipient described on this form is not required by law to protect the privacy of the information.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment at this facility or eligibility for benefits or enrollment in a health plan.
- Release of HIV-related information requires additional authorization.
- I will be provided with a copy of this form after I have signed it.
- I may refer to this entity's Notice of Privacy Practices for information regarding the use and disclosure of PHI requiring authorization.
- I may revoke this authorization in writing at any time and understand that the revocation will not have any effect on any action taken by the facility in reliance on this authorization before written notice of the revocation is received by the facility's Privacy Officer or designee.

Expiration of Authorization

This authorization expires one (1) year after the date it is signed by the person with authority to consent unless otherwise designated here:

____.

Signature

I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use or disclosure of my PHI.

Signature: ____ **Printed Name**: ____
(Patient/parent/legal guardian) (Patient/parent/legal guardian)

Name and Title of Person Obtaining Authorization: ____

Date: ____________________________________

Contact Information of the person signing the consent:

Complete Address: ____

Telephone/daytime: ______________________________________ Telephone/evening: ______________________________________

FOR FACILITY USE ONLY

Date facility received request to revoke authorization: ____

Name and title of person handling request to revoke authorization: ____

Action taken by facility on revocation: ____

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