Giombetti & Brady
PEDIATRICS

208 Delaware Avenue, Delmar, NY 12054
Phone: (518) 439-5611 Fax: (518) 439-9576

RECORDS RELEASE

Consent for Release of Protected Healthcare Information

Use this form to allow Giombetti & Brady Pediatrics to share your protected health information with an individual or organization.

I acknowledge that I have been notified about HIPAA and the HIPAA policies of Giombetti & Brady Pediatrics.

A PATIENT INFORMATION

Name _____ **Date of birth** _____

Address _____ **City** _____

State _____ **ZIP** _____ **Daytime phone** _____

B PERSON OR ORGANIZATION THAT MAY RECEIVE YOUR INFORMATION

Note: if information is shared with a person or organization that is not legally required to obey privacy laws, the information may be shared with others and is no longer protected.

Please write the first and last name of the person, and the most detailed name possible for an organization (e.g. hospital name, therapist, parent).

Recipient's full name _____

Address _____

Phone _____ **Fax** _____

Please check the box describing the person or organization's relationship to you:

- ☐ School
- ☐ Family member
- ☐ Friend
- ☐ Health care provider / mental health care provider
- ☐ **Other (describe)** _____

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C PROTECTED HEALTH INFORMATION TO BE SHARED

Check one.

☐ Any and all information (including personal, health, demographic, claims, billing, and medical records).

☐ Only limited information (such as for specific treatments, dates of service, or billing details).

Please describe _____

Please check below if you DO NOT want to include any of the following highly protected information, known as Super PHI:

☐ Substance abuse records (including alcoholism)

☐ AIDS or HIV treatment records

☐ Mental health services (does not include psychotherapy notes)

D EXPIRATION AND CANCELLATION

This permission will expire (check one box only).

☐ **On this date (MM/DD/YYYY)** _____

☐ No expiration

I understand that cancellation will not apply to information that has been released by a third party due to this authorization.

Initials _____

E AUTHORIZATION AND SIGNATURE

I allow the use and disclosure of my protected health information as described above. This information is being released at my request.

Signature of parent or legal guardian if patient is under 18

Sign _____ **Date** _____

Print _____

Signature of patient if 18 or older

Sign _____ **Date** _____

Print _____