Giombetti & Brady Pediatrics
Phone: (518)-439-5611

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

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 HIPPA and the HIPPA policies of Giombetti & Brady Pediatrics.

A) PATIENT INFORMATION

NAME:______________________________________ **D.O.B:**_____________

ADDRESS:________________________________ **CITY:**____________

STATE:___________ **ZIPCODE:**_____________ **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 first and last name of person, and the most detailed name possible for an organization. (ex: hospital name, therapist, parent)

RECIPIENTS' FULL NAME: ____

ADDRESS:____

PHONE:_____________________ **FAX:**________________________

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

- ☐ SCHOOL
- ☐ FAMILY MEMBER
- ☐ FRIEND
- ☐ HEALTH CARE PROVIDER / MENTAL HEALTH CARE PROVIDER
- ☐ OTHER (describe) ____

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 (month, day, and year, 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:_______________________________________