MONROE PEDIATRIC ASSOCIATES – A DIVISION OF ALLIED PHYSICIANS GROUP (APG)

70 GILBERT STREET, MONROE, NY 10950 (845) 782-8616

PATIENT GENERAL AUTHORIZAITON FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Monroe Pediatric Associates to use and/or disclose certain protected health information about me (if signed by patient) or about my minor child/children for whom I legally act as parent (in loco parentis) (if signed by parent or patient personal representative*) as listed below

Patient(s) Name	DOB	Age	My Relationship to Patient
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To: (Check and fill in those that Protected Health Information (PHI) can be released to)

_____School/Employer_____

(Please list full name of school district name/institution name such as preschool, daycare, after-school program, college or employer)

_____Camp_____

(Please list full name of camp)

_____Sports/Activities_____

(Please list sports/activities (other than school) such as Little League, Scouts, etc.)

_____Special Education/Needs Program_____

(I.E.. BOCES, Inspire Family Empowerment, Occupations, WIC, etc.)

_____Parent or Other Person _____

(Please specify name)

I authorize that the following information may be released to the organizations designated above:
(Check all types of information that can be released)

_____immunization updates
_____activity restrictions/limitations
_____return to work/school note
_____physical exam/health info. Form
_____authorization/directions for medications
_____Other (please specify) _____

The information will be disclosed for the purpose of satisfying record-keeping requirements of requesting organizations at the request of patient or patient personal representative. These purposes are listed so that I can make an informed decision whether to allow release of the information.

Our practice will not receive payment or other remuneration from a third party in exchange for using or disclosing this PHI. However, for certain disclosures, Monroe Pediatrics is reimbursed for copying costs.

I do not have to sign or fill out this authorization in order to receive treatment at Monroe Pediatric Associates. In fact, I have the right to refuse to sign this authorization. I will receive a copy of this authorization if requested. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing. This will not revoke any information that has already been released in accordance with this authorization. My written request to revoke this authorization must be submitted to the privacy Officer at: Monroe Pediatric Associates, 70 Gilbert Street, Monroe, NY 10950.

*If patient personal representative who is not parent signs form, documentation may be required to determine if person is legally able to sign on patient's behalf.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

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Print Name of Patient/Parent/Legal Guardian

Note: Individual patients are required to sign their own authorization form if they are 18 years or over, emancipated, or become parents.