SCHOOLHOUSE PEDIATRICS

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION AND FINANCIAL AGREEMENT

81 Schoolhouse Road
Albany, NY 12203
PH: 518-456-1211
Fax: 518-452-2535

1750 Route 9
Clifton Park, NY 12065
PH: 518-344-6706
Fax: 518-357-3341

270 Mansion Street
Coxsackie, NY 12051
PH: 518-731-3800
Fax: 518-731-3838

Patient Name(s):_____ DOB: _____
Patient Personal Cell Number: (if over the age of 18) _____
Ethnicity (Latino, Non-Latino, Other):_____Primary Language: _____
Race (Asian, Black, Hispanic, White, Other):_____

People/Organizations who may share information: (Please List)

_____ **School/College**: _____

_____ **Camps**: _____

_____ **Other:** _____

_____ **Relative: (please list names)** _____

Please circle YES or NO to the information that you would or would NOT want released:

Yes / No	My Yearly Physicals (including for college)	**Yes / No**	Any Hospital Visits That I Have Had
Yes / No	My Immunizations	**Yes / No**	Gynecology Appointments (for females only)
Yes / No	My Med Consults	**Yes / No**	My Lab Work
Yes / No	My Sick Visits	**Yes / No**	Specialists (Urology, Psychiatrist, Dermatology…)
Yes / No	My Medication(s) I am Taking	**Other:**	_____

OR you may choose:

_____I do not wish to have ***any*** of my medical information to be given to anyone.

This authorization is valid for: (check one)

_____ This request only

_____ One year from the date of this authorization **OR** _____ (insert date)

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and is revocable by me in writing, except to the extent that Schoolhouse Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to the Schoolhouse Pediatrics Privacy Officer at address listed above. Any health information disclosed by Schoolhouse Pediatrics pursuant to this authorization may be subject to re-disclosure by the recipients and may no longer be protected by the Federal HIPAA privacy regulations. Schoolhouse Pediatrics may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization. If you have Medicaid Fee for Service, not through a Managed Care Program, and you decide to receive care in our office, you agree that you are a private pay patient and we will render the service under this agreement. This means you will be responsible for the medical bill as we do not participate with the Medicaid Fee for Service Program.

_____ _____
Signature of Patient or Patient Representative — Today's Date

_____ _____
Printed name of Patient or Patient Representative — Relationship to Patient