

# SCHOOLHOUSE ROAD PEDIATRIC ASSOCIATES, P.C.

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

11835 Rt. 9W, Suite 3  
West Coxsackie, NY 12192  
PH: 518-731-3800  
Fax: 518-731-3838

Patient Name: \_\_\_\_\_ 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 Road Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to the Schoolhouse Road Privacy Officer at address listed above. Any health information disclosed by Schoolhouse Road Pediatrics pursuant to this authorization may be subject to re-disclosure by the recipients and may no longer be protected by the Federal HIPPA privacy regulations. Schoolhouse Road 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