Decerina Uy MD, P.C.
649 Route 25A Suite 3 Rocky Point, New York 11778
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AUTHORIZATION FOR RELEASE OF INFORMATION BY PATIENT 18 YEARS OLD AND OVER

Patient Name: _____ Date: _____

Patient DOB: _____

I understand that it is the policy of DECERINA UY PEDIATRICS to protect my privacy and to follow all state and federal privacy laws. However, I also understand that in order to involve my parents or other individuals in my medical care it will be necessary for the Practice to use/disclose some of my medical information ("Protected Health Information"). I understand that my Protected Health Information to be disclosed may include information regarding genetic testing, HIV/AIDS status, sexually transmitted infection status, mental health diagnosis and treatment, and treatment and substance abuse diagnosis and treatment, and pregnancies and/or pregnancy test results. I hereby specifically authorize the Practice to disclose such information to the persons listed below:

I hereby authorize the disclose of my Protected Health Information to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patients Rights

I understand that I have the right to refuse to sign this Authorization to release my Protected Health Information. If I refuse to sign this Authorization, the Practice will in no way deny me my rights concerning treatment, payment for services, and enrollment in a health plan or eligibility for benefits.

I understand that I may revoke this Authorization at any time after I have signed it by providing Decerina Uy M.D. PC with a written statement that I wish to revoke this Authorization. My revocation of Authorization will be effective immediately and my Protected Health Information will no longer be used/disclosed pursuant o this Authorization except when medically necessary in an emergency situation.

I specifically authorize the disclosure of my Protected Health Information as set forth in the Authorization. I understand that if my Protected Health Information is disclosed, then this information may be subject to re-disclosure by the recipient and may no longer be protected by the federal patient privacy laws.

This Authorization, unless I earlier revoke it, shall remain in effect for as long as I am an active patient at the Practice.

_____
Patient's signature