

<p>Step 5 completed</p> <input type="checkbox"/>	<p>STEP 5: <u>Statement of understanding and signature</u> Your signature on this page indicates that you agree to the disclosure or release of medical information described above <i>and</i> that you understand the following:</p> <ul style="list-style-type: none"> • This authorization is valid for 90 days from the date of signature. • You may revoke this authorization at any time by sending a written request for revocation to the provider named in Step 2 above. This revocation, however, will not affect any actions taken by the releasing provider before he/she received my written revocation. • Our medical treatment cannot and will not be dependent upon your signing this authorization. • The medical information that is the subject of this form <i>may not be protected by the federal privacy regulations if or when it is redisclosed</i> by the person, group, or institution you are authorizing to receive it. • There is a charge for each request for copies of medical records in accordance with regulations established by the Board of Registration in Medicine. <p style="text-align: right;">_____ Patient's signature</p> <p>_____ Witness Signature</p> <p style="text-align: right;">_____ Parent's or Guardian's Signature</p>
<p>Step 6 completed</p> <input type="checkbox"/>	<p>Step 6: <u>Sensitive Information:</u></p> <p>I AGREE TO THE RELEASE of the information in my medical record that relates to drug and/or alcohol abuse, psychiatric care, history of sexually transmitted disease, social service consultations, hepatitis testing/treatment, and/or other sensitive information.</p> <p>_____ Signature of Patient or Legal Guardian</p> <p style="text-align: right;">_____ Date</p>
<p>Step 7 completed</p> <input type="checkbox"/>	<p>Step 7: <u>HIV Information:</u></p> <p>IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV(AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW.</p> <p>I AGREE TO THE RELEASE OF THE HIV INFORMATION IN MY MEDICAL RECORD.</p> <p>_____ Signature of Patient or Legal Guardian</p> <p style="text-align: right;">_____ Date</p>
	<p>I UNDERSTAND THAT UPON TRANSFER OF CARE, GARDEN CITY PEDIATRIC ASSOCIATES, LLC IS UNABLE TO PROVIDE APPOINTMENTS, TELEPHONE TRIAGE AND/OR REFERRALS.</p> <p style="text-align: right;">_____ Initial</p>

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA"). This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Garden City Pediatric Associates will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.**