DAYSTAR KIDS

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

ENROLLEE/CHILD'S INFORMATION	
Enrollee's Name:	Birth date: / /
Address:	Phone #: ( )
City/State/Zip:	Social Security #: XXX-XX-

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, parent/guardian of the child listed above ("enrollee") authorize any health plan, physician, health care provider, clinic, laboratory, pharmacy, medical facility, early intervention/school system, or other service provider that has provided treatment or services to the enrollee listed above to disclose all records and any other Protected Health Information (PHI) to, or discuss the enrollee's information with Daystar Kids at 700 Lac De Ville Blvd., Rochester, NY 14618.

- This authorization also allows Daystar Kids to send copies of the enrollee's record to (or discuss the enrollee's information with) the enrollee's health care and service providers.

PURPOSE AND NEED FOR DISCLOSURE: CHECK ALL THAT APPLY

✓ To determine eligibility for Daystar Kids programs/services	✓ To coordinate/provide EI/Preschool services
✓ Health care / treatment purposes	✓ To facilitate Medicaid/Waiver enrollment
✓ To facilitate and coordinate OPWDD services/programs	✓ To facilitate/coordinate CompassionNet services
	✓ To coordinate/provide educational services

TYPE OF RECORDS/INFORMATION REQUESTED: CHECK ALL THAT APPLY

✓ Inpatient treatment records: discharge summary, hospital/physical, laboratory tests, x-ray, operative reports, pathology
✓ Entire copy of inpatient treatment records/reports and health history
✓ Outpatient/Office Visits treatment records/reports and health history: clinic/doctor/dental visits, laboratory test results, ambulatory surgeries, immunizations, emergency department, x-ray/radiology, or other health history reports
✓ Educational/Developmental Services records/reports: includes EI, Preschool, and School District records and evaluations

- Mental health and alcohol/drug treatment records are not included in this authorization unless authorized separately.

EXPIRATION DATE/ EVENT: CHECK ONE BOX ONLY

☑ This authorization is valid for the entire period that the child is enrolled in programs and/or receives services from Daystar Kids and will terminate upon the child's discharge from Daystar Kids programs and services; or

☐ This authorization will end on_____ (specify date/event). The following is/are other criteria or limitations that I make regarding this Authorization: _____.

While this Authorization for Release of Records ("Release") remains in effect, I hereby grant, to the fullest extent possible, Daystar Kids, all rights and applicable authorizations to contact all medical and service providers via telephone, electronic mail, regular mail, facsimile, and/or any other means for purposes of accessing and/or obtaining information pursuant to this Release.

I understand that:

- My child's right to health care treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to Daystar Kids at the address below, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed; except those records protected by Federal Confidentiality Rules 42CFR, Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional authorization (NYS DOH 2557).
- The records requested above may be faxed or emailed.
- I acknowledge that I/we have received a copy of Daystar Kids Notice of Privacy Practices.
- I understand that the information used or disclosed pursuant to this authorization may be re-disclosed by the recipient, and that the information will no longer be protected by the Agency or the HIPAA Privacy Rules.

PARENT/GUARDIAN SIGNATURE

Signature:	_____	Date: / /
Relationship to Enrollee:	_____	

This authorization must be retained for a minimum of six (6) years beyond the validation limits. Rev 02/2022