UNIVERSITY of ROCHESTER MEDICAL CENTER
& Affiliates

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Strong Memorial Hospital
Department or Practice General Pediatrics
601 Elmwood Avenue, Box #: 632
Rochester, NY 14642
Phone: (585) 275-2821 Fax: (585) 461-1231

RR DONNELLEY

SH 48GPED MR Authorization for Release/Disclosure of Medical and/or Behavioral Health Information

PLEASE PRINT
Patient name: _____ Date of Birth: _____
Address: _____ Patient's phone#: ( ) _____
City/State/Zip: _____

This Authorization allows URMC & Affiliates to: (check one or both)

☒ **SEND** copies of your record to (or discuss your information with) the provider/person/facility below

☒ **RECEIVE** copies of your record from (or discuss your information with) the provider/person/facility below

YMCA of Greater Rochester
Name of Provider/ Person/Facility

444 E. Main St.
Address

Rochester, NY 14604
City, State, Zip Code

585-546-5500
Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: ☐ Healthcare or Appointment **(date)** _____ ☐ Insurance ☐ Other

TYPE OF RECORDS or INFORMATION REQUESTED: Check all that apply:

The records requested are to include: ☐ Mental Health Treatment Records ☐ Alcohol/Drug Treatment Records
(Release/disclosure of HIV-related information requires additional authorization on form NYS DOH2557 or OCA 960)

☐ **Inpatient admission(s)/date(s):** _____
(Check only one of the following 3 choices if requesting inpatient records)
- ☐ Treatment summary (includes discharge summary, history/physical, laboratory tests, x-ray reports, operative reports, pathology)
- ☐ Specific information or reports (describe): _____
- ☐ Other (describe): _____

☒ **Outpatient/Office visits--date(s):** _____ **and/or specific illness/injury:** _____
(Check type of outpatient visit to be released)
☐ Clinic/doctor/dental visit ☐ Ambulatory Surgery visit ☐ Emergency Department Record
☐ Radiology report(s) ☐ Laboratory test results ☐ Immunizations ☐ Physical/occupational therapy record(s)
☒ Other (describe): Telemedicine Visit

AUTHORIZATION VALID FOR: (If nothing is checked below, this authorization is valid for this request only.)
☐ This request only
☒ One year from the date of this authorization **OR** _____ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.
☐ This request **and** for medical records of any **future** treatment of the type described above until: _____(insert date)

I understand that:
- My right to healthcare treatment is not conditioned on this authorization, except in very limited circumstances (e.g. non-emergent mental health or chemical dependency treatment).
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, 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 that chemical dependency treatment records protected by Federal Confidentiality Rules 42CFR Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.
- There may be a charge for the requested records.
- The medical records requested above may be faxed in cases of medical necessity.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if Representative)* _____

Revised 8/11

Distribution: Original to medical record. Copy to patient as required.

This authorization must be retained for a minimum of six years beyond the validation limits.

HIGHLAND HOSPITAL
STRONG MEMORIAL HOSPITAL

TELEHEALTH CONSENT

SH 419TELE MR

419

Name:

Date of Birth:

R.R. DONNELLEY

This consent is for all telehealth services provided for the following condition(s): Pediatric Illness.

1. I understand that my health care provider wishes me to engage in a telehealth appointment/consultation to evaluate my health condition.

2. My health care provider has explained to me that either video conferencing technology and/or electronic transmission of my health information such as radiologic images, photos and sounds will be used during this appointment/consultation and it will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand that there are risks associated with use of this technology such as interruptions, technical difficulties, and inability to obtain information sufficient for decision making about my health problem and that all possible precautions will be taken to minimize these risks. In addition, my health care provider or I can discontinue the telehealth visit if it is felt that the information obtained through the telemedicine connection is not adequate for diagnostic decision-making or for implementing management of my health problem. In that event, we will endeavor to facilitate access to a site where adequate care can be provided, such as a doctor's office or other source of in-person care.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the appointment/consultation and thus will have the right to request the following:
   (a) Omitting specific details of my medical history/physical examination that are personally sensitive;
   (b) Asking non-medical personnel to leave the telemedicine examination room; and/or
   (c) Terminating the consultation at any time.

5. The alternatives to a telehealth appointment/consultation have been explained to me. In choosing to participate in a telehealth appointment/consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I understand that billing may occur from both my health care provider and the facility I am presenting at for my appointment.

8. I have had a direct conversation with my health care provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify that:

- I have read or had this form read and/or had this form explained to me
- I fully understand its contents including the risks and benefits of the telehealth appointment/consultation
- I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction.
- I consent to this telehealth appointment/consultation.
- I have been provided with the University of Rochester Medical Center and Affiliates Notice of Privacy Practices.

Patient/Parent/Guardian Signature	Date	Time

TO BE COMPLETED BY STAFF
No signature was obtained due to:

- ○ Impractical, verbal consent given
- ○ Patient's condition/capacity
- ○ No representative

Staff Signature	Date	Time