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 _____, 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 to send copies of the enrollee's record to (or discuss the enrollee's information with) the enrollee's medical and service providers.

**PURPOSE AND NEED FOR DISCLOSURE: INITIAL ALL THAT APPLY**

| | |
|---|---|
| ____to determine eligibility for Daystar's programs | ____ to coordinate delivery of therapeutic services |
| ____ healthcare / treatment purposes | ____ to facilitate Medicaid Waiver Eligibility |
| ____to facilitate OPWDD Eligibility | ____ to facilitate Compassionet Eligibility |
| | ____ to coordinate educational services |

**TYPE OF RECORDS/INFORMATION REQUESTED: INITIAL ALL THAT APPLY**

_✓_ Inpatient treatment summaries: discharge summary, hospital/physical, laboratory tests, x-ray reports, operative reports, pathology

_✓_ Entire copy of inpatient treatment records and health history

_✓_Outpatient/Office Visits treatment records and health history: includes clinic/doctor/dental visits, laboratory test results, ambulatory surgeries, immunizations, emergency department records, x-ray reports, or other health history reports

_✓_ Educational / Developmental Services Records: includes Early Intervention and School District records, evaluations, and reports

- ✓ 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 Daystar's programs and/or receives services from Daystar and will terminate upon the child's discharge from Daystar's 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/we understand that:

- ✓ My child's right to healthcare treatment is not conditioned on this authorization.
- ✓ I may cancel this authorization at any time by submitting a ***written request*** to Daystar 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/we acknowledge that I/we have received a copy of **Daystar's Notice of Privacy Practices**.
- ✓ I/we 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(S)**

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

*This authorization must be retained for a minimum of six (6) years beyond the validation limits. Rev 12/2018*

**Daystar Kids Pediatric Respite Center Referral**
**FAX to (585) 383-0033** or call (585) 385-6287
Visit **daystarkids.org** for more information

DAYSTAR KIDS

Child's Name:_____ (M or F) DOB: ___/___/___ If Newborn: GA: _____

Medicaid:_____ CIN #_____
(required)

Parent/Guardian Name:_____

Address:_____

Phone: _____ (Cell) _____ Email: _____

Child has been evaluated for Early Intervention Services YES NO

## Eligibility Information

| Diagnoses | ICD9 Code | Diagnosis | ICD9 Code |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Please check which of the following criteria are met by the child's current medical condition:

| | |
|---|---|
| | Requires medical device(s) to maintain health status |
| | Requires continuous skilled assessment and monitoring of child's medical conditions |
| | Medical conditions require clinical nursing services and daily nursing supports (medication or oxygen administration, respiratory therapy, cardiac monitoring, seizure management, dressing changes, ostomy care, etc.) |
| | Special developmental needs requiring intensive therapeutic interventions and/or special education support |

Please provide relevant medical history justifying medical eligibility:

_____

_____

_____

_____

_____

_____

Immediate Needs:_____

_____

**NOTE: PHI Consent Form must accompany this referral form in order to expedite eligibility decisions. Additional information may be required. Placement is based on eligibility and available openings.**

Referring Provider Name:_____

Relationship to patient:_____Agency/Affiliation_____

Email: _____Phone: _____

Referring Provider Signature **(REQUIRED)**: _____Date:_____

Date Received: _____ Reviewed by: _____