


PROVIDENCE PEDIATRICS, LLC

AUTHORIZATION FORM FOR USING AND DISCLOSING HEALTH INFORMATION

Section A: Must be completed for all authorizations.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information no longer be protected by federal privacy regulations.

Patient Name: _____ Birth date: _____

ID Number: _____

Persons/Organizations Providing the Information:

**Providence Pediatrics, LLC
1462 Montreal Road, Suite 212
Tucker, GA 30084**

Persons/Organizations Receiving the Information:

Specific Description of Information (Including Dates):



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Section B: Must be completed only if the healthcare organization has requested the authorization.

1. The health plan or health care provider must complete the following:
 - a. What is the purpose of the use or disclosure:
Continued medical care _____
 - b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes___ No___
2. The patient of the patient's representative must read and initial the following statements:
 - a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials:** _____
 - b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. **Initials:** _____

Section C: Must be completed for all authorizations.

The patient of the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire in one (1) year from the date signed.
Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before the received the revocation.
Initials: _____

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 1 year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: _____
(Patient)

Date: _____

Or By: _____
(Patient's Representative)

Date: _____

Description of Representative's Authority _____

