

# **PROVIDENCE PEDIATRICS, LLC**

## **Authorization For The Use And/Or Disclosure Of Protected Health Information**

I authorize the use and/or disclosure of my protected 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 is no longer protected by federal privacy regulations.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Persons/ Organizations **Receiving** Medical Information (include address and fax):

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My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization:

- Inpatient / Outpatient physician notes
- Labs / Xray reports
- Immunization records
- Other: \_\_\_\_\_

I authorize the following persons (or class of persons) to **release** my protected health information:

Providence Pediatrics, LLC  
Erica Y. Francis-Scott, MD  
2171 Northlake Parkway, Ste 114  
Tucker, GA 30084  
Phone 770-939-7477 Fax 770-939-7750

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

This authorization expires 1 year from the date of signing.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Providence Pediatrics, LLC, nor will it affect my eligibility for benefits.

My protected health information will be used or disclosed upon request for the following purposes:

- Continuation of medical care
- Health care operations
- Other: \_\_\_\_\_

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).

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**Signature**

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**Date**

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**Print Name of Representative**

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**Relationship to Patient**