SPECTRUM PEDIATRIC GROUP

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Spectrum Pediatric Group to use and/or disclose certain protected health information (PHI) about my child, _____ to _____. This authorization permits Spectrum Pediatric Group to use and/or disclose the following individually identifiable health information about my child

A) Complete medical records

B) Records for the following days _____

C) Immunization records

This authorization will expire on _____

I do not have to sign this authorization in order to receive treatment from Spectrum Pediatric Group. Infact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Spectrum Pediatric Group at: 3104 Creekside Village Dr, Suite 504, Kennesaw, GA 30144

Signed by:_____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian