Ancient City Pediatrics

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PATIENT AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my authorization for Ancient City Pediatrics, LLC, to use and disclose protected health information about my child/children to carry out treatment, payment and healthcare operations. Ancient City Pediatrics, LLC's, Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this authorization. Ancient City Pediatrics, LLC, reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With this authorization, Ancient City Pediatrics, LLC, or the appointed representatives may call/mail my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out healthcare operations, such as, appointment reminders, patient statements, insurance items and any calls pertaining to my child's clinical care, including laboratory/radiology results among others.

With this authorization, I have the right to request that Ancient City Pediatrics, LLC, restrict how it uses or discloses my protected health information to carry out healthcare operations. However, Ancient City Pediatrics, LLC, is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am authorizing Ancient City Pediatrics, LLC, and/or its representative's use and disclosure of my protected health information to carry out healthcare operations. I may revoke this authorization in writing except to the extent that Ancient City Pediatrics, LLC, has already made disclosures in reliance upon my prior authorization.

If I do not sign this form, I am authorizing that Ancient City Pediatrics, LLC, may decline to provide treatment.

I ______________________________, have received and reviewed a copy of Ancient City Pediatrics, LLC's, Notice of Privacy Practices. By my signature, I acknowledge understanding of the Notice of Privacy Practices.

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Child's Name

____
Signature of Parent/Guardian

____
Date

**OFFICE USE: we attempted to obtain written acknowledgment but could not due to:

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Initials: _________