PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, authorize Mid City Pediatrics, L.L.P. to use and/or disclose certain protected health information (PHI) about me to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization permits Mid City Pediatrics to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____ Billing information _____ Lab results _____ Appointments _____ Medical Records _____Phone calls

This information will be used or disclosed for the following purpose: _____

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

The Practice will not receive payment of other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Mid City Pediatrics, L.L.P. In fact, 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 Privacy Officer at: 2225 Line Avenue, Shreveport, LA 71104.

Patient's Name: _____ Date: _____

Patient or Guardian: _____ Relationship: _____

Signature: _____ Relationship: _____