THE WORLD OF PEDIATRICS

LYUDMILA VAYMAN, M.D., F.A.A.P.

Patient Authorization for Use and Disclosure of Protected Health Information (PHI)

By signing, I authorize **The World of Pediatrics** to use and/or disclose certain protected health information (PHI) about me. Failure to authorize release of PHI may prevent the exchange of vital information associated with care delivery.

This authorization permits **The World of Pediatrics** to use and/or disclose the following health information (please check all that apply):

___ Office Notes (MD notations)
___ Radiology reports (including ultrasound, MMR, Cat scans, x-rays etc.)
___ Hospital records (Operative notes and Pathology reports, admission and discharge summaries)
___ Other _____

The information will be used for the following purpose:

___ At the request of patient
___ Other _____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of information. The practice will not receive payment or other remuneration from a third party in exchange for disclosing PHI, however, in some cases there is a fee collected for copying records.

___ I hereby give my consent for **The World of Pediatrics** to use and disclose PHI about me or my child to carry out treatment, payment, and health care operations (TPO).
___ I have the right to review the Notice of Privacy Practices prior to signing this consent. **The World of Pediatrics** reserves the right to revise its Notice of Privacy Practices at any time. A written Notice may be obtained by writing to the Privacy Office of WOP, 3005 Royal Boulevard South, Suite 110, Alpharetta, GA 30022
___ With this consent **The World of Pediatrics** may call my home or other location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any calls pertaining to clinical care including lab results, among others.
___ With this consent **The World of Pediatrics** may mail to my home or other location any items that assist the practice in carrying out TPO, such as reminder cards and statements.
___ I understand that I do not have to sign this release to receive treatment at **The World of Pediatrics.** I also have the right to revoke this authorization at any time by requesting such in writing to the Privacy Officer of WOP.

_____ _____200

Signature/ Printed Name Date

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