

PEDIATRIC

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Authorization to Treat and Release Information

I authorize treatment and release of any medical information (required in my treatment) to process claims filed with my insurance company. I authorize direct payment from my insurance company to my provider. At any time, should I decide that I want to file my own claims, I understand that payment in full will be required at the time of service. I also understand that I will be financially responsible for all charges incurred.

I have received a copy of the Pediatric Associates of Savannah, PC “Notice of Privacy Practices,” which details how my personal health information may be used and disclosed as permitted under federal laws. I have read and understand the contents of the notice.

I agree that Pediatric Associates of Savannah, PC may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

I authorized Pediatric Associates of Savannah, PC to release medical information to GRChIE (health information exchange) for treatment purposes.

I authorize Pediatric Associates of Savannah, PC to send emails and text messages for the purpose of appointment reminders, billing statements, and general practice information.

Signature

Date