

# PEDIATRIC

## ASSOCIATES OF SAVANNAH

Michael D. De Mauro, MD, FAAP  
Diane R. Savage-Pedigo, MD, FAAP  
Paul L. Nave, MD, FAAP  
Ben Spitalnick, MD, MBA, FAAP  
Steve Hobby, MD, CPC, FAAP  
Adria H. Wilkes, MD, FAAP

Chintak B. Patel, MD, FAAP  
Brandy Gheesling, MD, IBCLC, FAAP  
Christopher C. Rogers, MD, FAAP  
Giselle M. Rosinia, MD, FAAP

**912.355.2462**

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4600 Waters Ave., Suite 100, Savannah, GA 31404 • 110 Medical Park Drive, Pooler, GA 31322  
1001 Memorial Lane, Savannah, GA 31410

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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 GRACHIE (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.

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Signature

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Date