Philip Spandorfer, M.D.
Ben Grinzaid, M.D.
Tracy Barr, M.D.
Steven Shore, M.D.
Tara Buckhalter, C.P.N.P.

Patient Consent for Use and Disclosure of Protected Health Information
18 Years of Age or Older

With my consent, FocusPediatrics may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Focus Pediatrics' Notice of Privacy Practices for a more complete description of such uses and disclosures. A copy of this notice is available on our website at www.focuspeds.com, or you may obtain a copy from a front desk associate before signing this consent.

I have the right to review the Notice of Privacy Practices before signing this consent. Focus Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. You may obtain a copy of our Notices of Privacy Practices, including any revisions of our Notice, at any time by contacting Focus Pediatrics, Privacy Officer at 1200 Lake Hearn Drive, Suite 275, Atlanta, Ga 30319.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Focus Pediatrics may decline to provide treatment to me.

Focus Pediatrics restricts how it uses or discloses PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

You may contact me at the phone number(s) listed below with test results and other medical information. I have checked the number I prefer you call.

☐ **Home** +1 (404) 661-5350 ☑ **Cell**

☐ **Email** darrell@agencynice.com

Darrell Jr			
Patient Name (printed)	Date of Birth	Patient Signature	Date

I authorize Focus Pediatrics to communicate with the following person(s) on my behalf. This authorization will continue until revoked in writing by me and supersedes all previous notifications.

Name	Relationship	Phone	Information to Provide (Circle)	
			Medical	Financial
			Medical	Financial

Patient Signature **Date**