

**Georgetown Pediatrics, PSC
1162 Lexington Road
Georgetown, Kentucky 40324
502-863-6426**

PATIENT AUTHORIZATION

On behalf of

(child's name)

_____,
date of birth,

I, _____,
(parent or guardian's name)

hereby authorize Georgetown Pediatrics, PSC to use or disclose the following specific medical records information:

For the purpose of:

to the person or entity listed here: _____

beginning on the date of _____.

I have the right to revoke this authorization in writing at any time. A written revocation should be sent to Georgetown Pediatrics, PSC at 1162 Lexington Road, Georgetown, KY 40324.

I understand that this authorization will automatically expire one year from the last date of service seen by this practice.

I realize that Georgetown Pediatrics, PSC will not condition its treatment of me, payment functions, or other health care operations based on whether or not I agree to this authorization, and that my participation is voluntary.

I realize that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected.

Georgetown Pediatrics, PSC will provide me a copy of this signed authorization.

Signature of Patient or Parent/Guardian

Date