GEORGETOWN PEDIATRICS, P.S.C.

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Medical Records Release (IN) Authorization

On behalf of,

______________________________ ______________________
(Patient Name) (Date of Birth)

____
(Guardian Name)

I hereby authorize the following person/physician/entity:

____
(Name) (Address)

____
(City) (State) (Zip)

To use or disclose the following specific medical records information: ______________________________

____

For the purpose of: ______ Treatment, Payment, or Healthcare Operations
______ Other (please explain): ______________________________

____

Beginning on the following date: ______________________

To:

Georgetown Pediatrics, P.S.C.
1162 Lexington Road
Georgetown, KY 40324

I have the right to revoke this authorization in writing at any time. A written revocation should be sent to the person/physician/entity listed above.

I understand that this authorization will automatically expire one year from the date of signature.

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

This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, alcoholism, drug-related abuse, and/or psychiatric/psychological conditions to the above mentioned entity.

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

Georgetown Pediatrics, P.S.C. will provide me a copy of this signed authorization.

______________________________ ______________________
(Patient/Guardian Signature) (Date)