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Medical Records Release (OUT) Authorization

On behalf of,

_____ _____
(Patient Name) (Date of Birth)

_____
(Guardian Name)

I hereby authorize Georgetown Pediatrics, P.S.C. to use or disclose the following specific medical records information:

_____

_____

Beginning on the following date: _____

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

_____

To the following person/physician/entity:

_____
(Name) (Address)

_____
(City) (State) (Zip)

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

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)