

## Medical Records Release (OUT) Authorization

On behalf of,			
(Patient Name)		(Date of Birth)	<del></del>
(Guardian Name)		<del></del>	
I hereby authorize Geo	orgetown Pediatrics, P.S.C.	to use or disclose the follo	wing specific medical records information:
Beginning on the follo	wing date:		
For the purpose of:	Treatment, Pay Transfer of Car Other (please of		ations
To the fo	ollowing person/physician	n/entity:	
(Name)		(Address)	
(City)		(State)	(Zip)
I have the right to revok 1162 Lexington Road, Ge		ng at any time. A written rev	ocation should be sent to Georgetown Pediatrics, P.S.C. at
I understand that this au	thorization will automaticall	y expire one year from the da	ate of signature.
	n Pediatrics, P.S.C. will not co e to the authorization, and the		payment functions, or other health care operations based ry.
			IV testing or treatment of AIDS or AIDS-related conditions, chological conditions to the above mentioned entity.
PSC will no longer be a appointments. This in Pediatrics, PSC and dec	vailable to see my child or cludes nursing telephone cide to do so in the future, I	children for regular appoin calls and prescription refi understand that I must tra	ther healthcare provider that Georgetown Pediatrics, ntments, evening appointments, weekend and holiday II requests. If I am eligible to return to Georgetown ansfer the entire care of my child or children from the requesting that the records be sent to Georgetown
I realize the information longer protected.	used or disclosed pursuant to	this authorization may be so	abject to re-disclosure by the recipient and no
Georgetown Pediatrics, I	P.S.C. will provide me a copy	of this signed authorization.	
(Patient/Guardian Signature)		(Date)	<u> </u>
Medical Records Format (choose o	one): Paper CD		