GEORGETOWN PEDIATRICS, P.S.C.

HORACE P. HAMBRICK, M.D., F.A.A.P
DAVID M. HODDY, M.D., F.A.A.P.
KRISTY K. MENKE, M.D., F.A.A.P.
JENNIFER S. RIEBEL, M.D., F.A.A.P.
ANN N. QUACKENBUSH, M.D., F.A.A.P.
JENNIFER S. OLIVER, M.D., F.A.A.P.
LAURA A. FORSTER, M.D., F.A.A.P.
LACEY B. SWEIGART, M.D., F.A.A.P.

1162 LEXINGTON ROAD
GEORGETOWN, KY 40324-9392
TELEPHONE: (502) 863-6426
FAX: (502) 868-9724

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)