

**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:

to use or disclose the following specific medical records information:

For the purpose of: _____ Treatment, Payment or Healthcare Operations
_____ Other

to: **Georgetown Pediatrics, PSC
1162 Lexington Road
Georgetown, KY 40324**

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 the above requested physician.

This authorization will expire one year from date of signature.

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.

Patient's or Personal Representative's Signature

Date