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Monday - Thursday 9:00am - 7:00pm

Appointments:
Monday - Thursday 1:00pm - 7:00pm

www.georgetownkids.com

Authorization to release Patient Medical Records

I hereby authorize the following information to be released from the medical record of:

Patient name: _____ Date of birth: _____

Address: _____ City: _____ St: _____ Zip: _____

Telephone #: _____ Social Security #: _____

THIS INFORMATION IS TO BE RELEASED **TO** Georgetown Kids:

THIS INFORMATION IS TO BE RELEASED **FROM:**

_____
Physician / Practice

_____
Address / City / State / Zip

_____
Phone / Fax

Information to be released: (check all that apply)
_____ Complete record
_____ Records of care from dates _____ to _____ only
_____ Records for drug or alcohol abuse or psychiatric illness

Initial and date for the following consent for release required:
I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.

_____ Initial _____ Date

The reasons or purposes for this release of information are:

_____

_____

Signed:_____ Date: _____
(Patient or person legally authorized to consent on patient's behalf)

Printed:_____