Georgetown Internists and Pediatricians dba
PAWLEYS PEDIATRICS AND ADULT MEDICINE
64 Business Center Drive, Pawleys Island, S.C. 29585
Phone: 843-314-1314 Fax: 843-314-1308

Authorization for Release of Health Information – HIPAA Compound Form

Patient______________________________ **Date of Birth**______________

Please check one: □ **General Information** □ **Detailed Information**
Phone #______________________________ E-mail______________________________
Text #______________________________ □ I do not wish to provide my e-mail address.
We need your email for encrypted Patient Portal communication. We DO NOT share your e-mail address.

Parent/Guardian______________________________ Relationship______________
(Parent/Guardian applies to Pediatric Patients Only)
Pawleys Pediatrics and Adult Medicine is authorized to release Protected Health Information about the above named patient in the following manner and to identified persons. This authorization shall remain in effect until revoked by the patient.

Please list each person/entity that you approve to receive information.

Name______________________________ Relationship______________
Phone #______________ Text #______________ Email______________
Discuss Medical Information: □ General □ Detailed **Discuss Financial Information**: □ General □ Detailed

Name______________________________ Relationship______________
Phone #______________ Text #______________ Email______________
Discuss Medical Information: □ General □ Detailed **Discuss Financial Information**: □ General □ Detailed

Name______________________________ Relationship______________
Phone #______________ Text #______________ Email______________
Discuss Medical Information: □ General □ Detailed **Discuss Financial Information**: □ General □ Detailed

Name______________________________ Relationship______________
Phone #______________ Text #______________ Email______________
Discuss Medical Information: □ General □ Detailed **Discuss Financial Information**: □ General □ Detailed

Healthcare Specialists (Ex. Gynecology, Cardiology, Gastroenterology, Endocrinology, etc) □ No Specialty Providers
For continuity of care, we have your permission to release and obtain your medical records to and from the following Providers:
Name______________________ Specialty______________ City__________
Name______________________ Specialty______________ City__________
Name______________________ Specialty______________ City__________
Name______________________ Specialty______________ City__________

Email / text communication waiver of liability
For direct email / text communication, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. Therefore, I □ **DO** □ **DO NOT** elect to receive email / text communication. ________ ***Initials***

____
Signature (Parent or Legal Guardian signatures will not be accepted for patients 18 years or older with exception to Personal Representative Documentation. Description of Personal Representative's authority must be provided. Attach necessary documentation such as court order or Power of Attorney.)

______________________________ Date ______________
Printed Name

I acknowledge I have read the Practice Policies and Notice of Privacy Practices and I understand I have the right to revoke this authorization at any time. ________ ***Initials***

□ **CCM:** Chronic Care Management services New CCM enrollment Date______________