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 – Medical Record Release

Option <u>required</u>: □ Expires upon one time release □ Expires by written request only

I authorize_____ Phone_____ Fax_____
to release requested medical information regarding:
Patient Name_____ **DOB**_____

Address_____ Phone_____

City_____ State_____ Zip_____ SSN_____

Covering the period(s) of treatment from_____ to_____

<u>Per my request, the following information may be released</u>: (check below)

□ Progress Notes	□ Radiology/X-Ray Reports	□ Laboratory/Pathology Reports
□ History and Physical	□ Operative Reports	□ Health Psychiatry/Psychology Notes
□ Immunization Record/Waiver	□ Discharge Summary	□ HIV/AIDS, STDs
□ Billing Records	□ Growth Chart	

□ Other (please specify)_____

Type of Access Requested: □ Copies of the record □ On-site record review by patient

<u>Purpose of Disclosure</u>: □ Transfer of Primary Care to_____

□ Personal Use □ Insurance □ Continuity of Care □ Legal □ Coroner □ DSS
□ Foster Care □ Subpoena □ Other (please specify)_____

Note: Over the counter or personal use *<u>fees</u>* are payable in advance with *<u>cash or certified check and picture ID.</u>*

<u>Entity or person who will receive the requested information</u>:

Name_____ Phone_____

Address_____ Fax_____

City_____ State_____ Zip_____

<u>How you want to receive the requested information:</u> (check below)

□ Pick up □ Mail □ Fax □ Email (***must have additional email encryption waiver signed***)

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand that released information may include a communicable disease diagnosis such as HIV/AIDS.

_____

Patient or Authorized Person Relationship Date

<u>Office Use Only</u>: □ Confirmation of signature of relationship to patient
□ Confirmation of signature on file
□ Power of Attorney or Legal Documentation Attached