

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 required: Expires upon one time release Expires by written request only

I authorize my previous healthcare provider (name) _____

Phone _____ Fax _____ to release requested medical information regarding:

My Name _____ **Date of Birth** _____

Address _____ Phone _____

City _____ State _____ Zip _____ SSN _____

Covering the period(s) of treatment from _____ to _____

Please release the following information: (check below)

- Progress Notes (last 2 only)
- Last Wellness Exam
- Most recent labs (last year)
- Other (please specify) _____
- Colonoscopy
- Mammogram
- DEXA/Bone Density
- Immunization Record

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

Purpose of Disclosure: Transfer of Primary Care to Pawleys Island Pediatrics and Adult Medicine
 Continuity of Care Personal Use

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

Entity or person who will receive the requested information:

Georgetown Internists & Pediatricians dba
Pawleys Island Pediatrics and Adult Medicine
64 Business Center Drive Pawleys Island, SC 29585
Phone: 843-314-1314 Fax: 843-314-1308

Please send my health information via: (check one) Fax E-mail (*signed e-mail liability waiver required*)
Mail Pick Up

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.

Sign here (Patient or Authorized Person) Relationship to patient? Date

Office Use Only: Confirmation of signature of relationship to patient
 Confirmation of signature on file
 Power of Attorney or Legal Documentation Attached

Scan to ecw\Medical Records\YYYY-MM-DD Medical Record Release