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) □ Colonoscopy □ Immunization Record
□ Last Wellness Exam □ Mammogram
□ Most recent labs (last year) □ DEXA/Bone Density
□ Other (please specify)_____

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:

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