Summerville Pediatrics

Internal Use Only:
Account #: _____ Chart #: _____
Date ROI Received: _____
Date Released: _____
☐ Faxed ☐ Mailed ☐ Picked up
Verified ROI & ID by _____

Authorization for Release of Protected Health Information

PLEASE PRINT CLEARLY AND COMPLETELY

Patient Full Legal Name: _____ Date of Birth: _____
Street Address: _____ Social Security #: _____
City, State, Zip: _____ Best Contact #: _____
Email Address: _____ May we leave a message at this number: _____

RELEASE INFORMATION FROM:

_____
Name of Facility or Practice

_____
Address

_____ _____
Phone Number Fax Number

RELEASE INFORMATION TO:

Summerville Pediatrics
Name of Facility, Person or Company

312 Midland Parkway
Address Summerville, SC 29485-8114

(843)875-6262 (843)873-7958
Phone Number Fax Number

PURPOSE OF RELEASE (check reason): ☐ Request of Individual/Personal Use ☐ Continued Patient Care ☐ Insurance ☐ Insurance ☐ Legal Purpose (including discussions & proceedings) ☐ Other

DATES OF TREATMENT OR DATE RANGE OF RECORDS TO BE RELEASED: From _____ to _____

PHYSICIAN PRACTICE INFORMATION TO BE RELEASED (check all that apply):
☐ Office/Clinic Summary (may include most recent office visits, physical exam, consults, and diagnostic test results) ☐ Progress notes
☐ Laboratory Reports ☐ Radiology Reports ☐ Other: _____ ☐ Entire Record (not including psychotherapy notes)

Fees May apply. You will be contacted about any charges that may apply, pursuant to SC Code Section 44-115-80.

Delivery Method (Check one)
☐ Regular US Mail ☐ Fax, where permitted **(NO MORE THAN 15 PGS.)** ☐ Pick-up ☐ Other: _____

Patient's Rights – I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetics, HIV/AIDS, and other sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- SP will not share or use my health information without my permission other than by ways listed in SP's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices was given to you in your new patient packet upon your initial visit.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless an earlier date of event is written here: _____

Print name: _____ Patient Signature: _____ Date: _____
NOTE: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Check relationship/authority if signature is not that of the patient (written proof may be requested):
☐ Parent ☐ Guardian ☐ Healthcare Agent/POA ☐ Affidavit/Next of Kin ☐ Spouse ☐Other _____

RETURN COMPLETED FORM IN PERSON, BY MAIL OR BY FAX WITH A COPY OF YOUR PHOTO I.D.

Summerville Pediatrics
312 Midland Parkway
Summerville, SC 29485
Phone: (843) 875-6262 Fax: (843) 873-7958