Medical Records Release Request

IMPORTANT NOTE: Please fill out the entire form. Any missing information may delay processing.

Release Medical Records ___ TO ___ FROM	Release Medical Records ___ TO ___ FROM
___ Palmetto Pediatrics ___ Sandhills Pediatrics	Practice Name: ______________________________
Email: medicalrecords@scpapeds.com*	Email: ______________________________
Address: ______________________________	Address: ______________________________
City: ____________________, SC, __________	City: ____________________ State: ________
Please do not fax medical records.	Zip: __________ Phone #:(_____)______________

*** Medical Records and/or Release Forms should be sent to our encrypted email:**
medicalrecords@scpapeds.com

Please release Medical Records for the following patient:

Patient Full Name: ____ Date of Birth:______________________

Purpose of Release of Records: ____

Medical Records Requested: (check all that apply)

__ Last Well Visit, Health Information Summary (including medication list), and Immunization Record (no charge)
__ Limited records including the dates of service specified here: ________________________
__ All medical records (may be subject to charge)
__ Psychiatric/Psychological evaluation notes (patients 13 years and older must consent to release if the parent was not present for the appointment)
__ Itemized Statement (no charge) – itemized statements will not be sent to other provider offices

Attestation:

- I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.
- I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
- I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the medical providers' office
- I understand that there may be a charge for obtaining the requested information. Information on the charge can be obtained by contacting the medical records staff.
- I understand that a copy of this document is just as valid as the original document.
- I understand that this authorization will expire in 90 days after signing unless an earlier date is specified here: ____________________________

Name of Person completing form (Printed): ____

Relationship to Patient: ______________________________ **Phone Number:** ________________________

Address: ____

Patient/Parent/Guardian Signature: ____________________________________ **Date:** ______________