2214 Old Cherokee Rd, Lexington, SC 29072 | 803.520.9380 | Fax 803.520.5972

Medical Records From:	Medical Records To:
______________________ Name of Facility	______________________ Name of Facility or Person Requesting Records
______________________ Address	______________________ Address
______________________ City, State, Zip Code	______________________ City, State, Zip Code
______________________ Phone Number	______________________ Phone Number
______________________ Fax Number	______________________ Fax Number

PATIENT: Please release medical record information and/or immunization record information for:

Patient Name: ______________________________ DOB: ____________________

▶ SCHOOL/DAYCARE: I authorize *Southern*MED Pediatrics to disclose the following protected health information (PHI) directly to __________________________ (list school or daycare) via ___ fax and/or ___ mail:

___ Doctor's excuse ___ Immunization record ___ Permission for medication

▶ EMAIL: I authorize *Southern*MED Pediatrics to send the following protected health information (PHI) via email: ___ Doctor's excuse ___ Immunization record

I understand that email is not a secure method of communication and is not recommended because it increases the risk that an unauthorized person may receive or interpret my protected health information. I release *Southern*MED Pediatrics from any liability for submitting PHI using email upon my verbal request and the signature on the following page.

▶ FAX: I authorize *Southern*MED Pediatrics to fax the following protected health information (PHI) to my work place: ___ Doctor's excuse ___ Immunization record

I understand that this is not recommended because it increases the risk that an unauthorized person may receive or interpret my protected health information. I release *Southern*MED Pediatrics from any liability for submitting PHI using my work's fax number upon my verbal request and the signature on the following page.

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▶ I am aware that if the medical record has information regarding substance abuse, psychiatric treatment, or communicable diseases, this information may be released.

Records Required/Date of Service: ____________ Complete Record ____________________________

Immunization __________________ Other (Please Specify) ___________________________________

Purpose of Disclosure: ____

____

▶ EXPIRATION: This release shall be in force and effect until the time or event specified below, at which time this release expires: ___ 1 year from signature date ___ Child turns 18 years old

I authorize the release of medical information to another provider/facility as deemed necessary for my treatment. I further authorize *Southern*MED Pediatrics, LLC to obtain medical information from another provider/facility as deemed necessary in the course of my treatment. This authorization may be revoked by me, in writing, at anytime. Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by HIPAA. My health care and payment for my health care will not be affected by refusing to sign this form. I understand that I may see and copy the information described on this form as requested.

I understand there will be a fee for copying medical records (other than immunization records and/or school excuses) as allowed by federal and state law up to $150 plus postage per child depending on the length of the patient's records.

I understand that it may take 30 days for medical records to be released and that SouthernMED Pediatrics may withhold records until the medical record fee is collected.

____ __________________________________

Patient/Parent/Guardian Signature **Date**

Address: ____

Telephone Number: (H) ____________________________ (W) _______________________________

When records are ready, I would like: ☐ Records mailed ☐ Records to be picked up at our office