Outgoing Medical Record Release Form

Patient Name: _____________________________________ DOB: _________________________

Medical Records From:

SouthernMED Pediatrics
2214 Old Cherokee Road
Lexington, SC 29072

Medical Records **□ mailed/faxed to**
□ picked up by

____
Name

____
Address

____
City, State, Zip Code

____
Phone Number

____
Fax Number

Records requested:

□ Immunization Record and last 3 office visits (no charge)

□ Complete Medical Record (***may be subject to charge***)

□ Other (Please Specify) ____

Purpose of Disclosure: ____

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 may be a fee for copying medical records as allowed by federal and state law. 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.**

____ ________________________________
Printed Name of Requestor | Relationship to patient

____ ________________________________
Patient/Parent/Guardian Signature | Date

Address: ____

Telephone Number: ________________________

This release expires 1 year from signature date above unless specified otherwise in writing.