Palmetto Pediatrics of the Lowcountry

Authorization for Release of Protected Health Information

Patient Name/Address: _____ **Date of Birth:** _____

_____

_____

This authorization permits the release of medical records from:

Provider's Name/ Address: _____

_____

_____

Phone Number: _____ Fax Number: _____

To: Palmetto Pediatrics

4 Okatie Center Blvd. S. Suite 201

Okatie, SC 29909

(p) 843-706-3206 (f) 843-998-7667

Information for treatment period: From (date) _____ To (date) _____

Information to be released:

__Immunization Records Only __All Medical Records __Other:_____

Reason for records to be released:

__Personal Copy **(Charges apply, see below.) __Legal Investigation**

__Transferring to Another Provider __Referred to Another Provider __Insurance

A) I understand that PHI (Protected Health Information) may include records disclosed by health care providers and facilities that previously provided treatment to me

B) I understand that PHI may include information and records protected under Federal Law (such as alcohol & drug treatment) and/or State Law (such as mental health, Aids or HIV).

C) I understand that I may revoke this authorization at any time, however the revocation will not apply to PHI that has already been used or disclosed. Revocations should be sent to address listed above.

D) I understand that Palmetto Pediatrics will not condition my treatment, payment, enrollment in health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

E) I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy standards.

F) I understand that this authorization will expire in ninety days after it is signed unless another date is specified here. _____

G) **I understand that I am financially responsible for the following fees associated with my request:**
HANDLING FEE: $25.00
POSTAGE: _____
COPYING CHARGE ($0.65/PAGE FOR FIRST 30 PAGES + $0.50/ANY ADDITIONAL PAGES)_____ TOTAL:_____

_____ _____ _____

Signature of Parent/Legal Guardian and Relationship to Patient | Printed Name | Date