

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 to: From: Palmetto Pediatrics

Provider's Name/ Address: _____ 4 Okatie Center Blvd. S. Suite 201

Okatie, SC 29909

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

Phone Number: _____ Fax Number: _____

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** Insurance

Transferring to Another Primary Care Provider Referred to Another Provider by Us

**Patient will be unable to transfer back to our office,
if transferring to a Primary Care in Beaufort County, SC.**

Reason for Transfer: _____

- 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