



PLANTATION PEDIATRICS

1871 Savage Rd, Charleston, SC 29407
105 Springhall Rd, Goose Creek, SC 29445
Phone: 843-766-6308 Fax: 866-533-4473

Authorization for Release of Protected Health Information

PLEASE PRINT CLEARLY AND COMPLETELY

Patient Full Legal Name: _____	Date of Birth: _____
Street Address: _____	Social Security #: _____
City, State, Zip: _____	Best Contact #: (_____) _____
Email Address: _____	May we leave a message at this number: <input type="checkbox"/> Yes <input type="checkbox"/> No

RELEASE INFORMATION FROM: <u>Plantation Pediatrics</u> Name of Facility or Practice <u>1871 Savage Road, Charleston, SC 29407</u> City, State, Zip <u>843-766-6308</u> <u>866-533-4473</u> Phone Number Fax Number	RELEASE INFORMATION TO: _____ Name of Facility, Person or Company _____ City, State, Zip _____ Phone Number Fax Number
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PURPOSE OF RELEASE (check reason): Request of Individual/Personal Use Continued Patient Care Relocating
 Legal Purpose Dissatisfaction with practice or provider

DATES OF TREATMENT OR DATE RANGE OF RECORDS TO BE RELEASED: From _____ To _____

PHYSICIAN PRACTICE INFORMATION TO BE RELEASED (check all that apply):
 Office/Clinic Summary (may include most recent office visits, physical exam, consults, and diagnostic test results)
 Progress Notes
 Laboratory Reports
 Radiology Reports
 Other: _____
 Entire Record (not including psychotherapy notes)

Fees May Apply. Requests for more than ten pages will be processed by our copy service who will contact you about charges that may apply pursuant to SC Code Section 44-115-80.

FORMAT <input type="checkbox"/> Paper copy We do not have the capabilities for email, cd's, or jump drives with patient records.	DELIVERY METHOD (check one) <input type="checkbox"/> Reg. US Mail <input type="checkbox"/> Pick-up <input type="checkbox"/> Fax, where permitted
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PATIENT'S RIGHTS – I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetics, HIV/AIDS, and other sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- Plantation Pediatrics will not share or use my health information without my permission other than by ways listed in Plantation Pediatrics Notice of Privacy Practices or as required by law. The Notice of Privacy Practices are available by request.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless an earlier date or event is written here: _____

Print Name: _____ **Patient Signature:** _____ **Date:** ____/____/____

NOTE: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Check relationship/authority if signature is not that of the patient (written proof may be requested):

Healthcare Agent/POA Guardian Executor/Administrator/Attorney in Fact Spouse
 Parent Adult Child Affidavit/ Next of Kin Other: _____