LOWCOUNTRY PEDIATRICS

...in the creek

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name

Patient Date of Birth

Street Address

Phone Number

City, State & Zip

Social Security Number

◊ I authorize Lowcountry Pediatrics to obtain information from:

◊ I authorize Lowcountry Pediatrics to release information to:

Physician / Practice Name / Entity

Street Address

City, State & Zip

Phone Number

Information Requested:

◊ Entire Chart

◊ Other

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign the authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

Signature of Parent/Legal Representative

Date

Printed Name of Parent/Legal Representative

Relationship to Patient

99 Bridgetown Road, Goose Creek, South Carolina 29445
Phone (843)572-3300 * Fax (843)797-3331