Palmetto Pediatric & Adolescent Clinic

140 Park Central Dr (DT)
Columbia, SC 29203
(803) 779-4001
Fax: (803) 252-9458

7428 Broad River Rd
(IRMO)
PO BOX 1365
Irmo, SC 29063
(803) 732-0140
Fax: (803) 732-4848

601 Clemson Road (NE)
Columbia, SC 29229
(803) 788-4886
Fax: (803) 788-5020

121 Blythewood Road
(BW)
Blythewood, SC 29016
(803) 788-6360
Fax: (803) 788-6668

1970 Augusta Highway
(LX)
Lexington, SC 29072
(803) 358-2370
Fax: (803) 358-2376

Authorization for Release of Protected Health Information

Medical Records To:

Clinic: **Palmetto Pediatrics**

Please Circle Location:

Downtown Irmo Northeast

Blythewood Lexington

Medical Records From:

Clinic:_____

Address:_____

City, State, Zip: _____

Phone:_____

Fax:_____

Please Release Records on the Following Patient:

Name:_____DOB:_____

Information to be Released: (Please Check All That Apply)

__All medical records (requested for all new patients)
__Last Well Visit, Health Information Summary (including medication list), and Immunization Record
__Psychiatric/Psychological evaluation notes (patients 13 years and older must consent to release if the parent was not present for the appointment)
__Itemized Statement
__Limited records including the dates of service specified here: _____

I understand that there may be a charge for obtaining the requested information _____ (Please initial)

Purpose of Release:_____

1.) I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.
2.) I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
3.) I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address noted on the top of this form.
4.) I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
5.) I understand that a copy or FAX of this document is just as valid as the original document.
6.) I understand that this authorization will expire in 12 months after signed unless an earlier date is specified here:
(please initial)_____

_____	_____	_____	_____
(Printed Name of Patient or Authorized Person)	(Signature of Patient or Authorized Person)	(Relationship to Patient)	(Date)

_____	_____	_____
(Home Address, City, State, Zip)	(Home Phone #)	(Cell/Work Phone #)

Provider Use Only:

Verification Completed By (staff initials): _____ Date:

_____

Revised : 10/17/2022