Medical Records Release Request

Release Medical Records ☐ TO ☐ FROM	Release Medical Records ☐ TO ☐ FROM
☐ Palmetto Pediatrics ☐Sandhills Pediatrics Email: medicalrecords@scpapeds.com (preferred) Address: _____ City: _____ State: _____ Zip: _____ Phone Number: _____ Please do not fax medical records.	Practice Name: _____ Email: _____ Address: _____ City:_____ State: _____ Zip: _____ Phone Number: _____

Medical Records or Release Forms may be sent to our encrypted email medicalrecords@scpapeds.com

Please Release Medical Records for the Following Patient:

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

Purpose of the Release of Records: _____

Medical Records Requested:

__Last Well Visit, Health Information Summary (including medication list), and Immunization Record (no charge)
__Limited records including the dates of service specified here: _____
__All medical records (no charge for emailing records, $5 charge for printing eChart or $10 charge for eChart and paper chart)
__Psychiatric/Psychological evaluation notes (patients 13 years and older must consent to release if the parent was not present for the appointment)
__Itemized Statement (no charge) – itemized statements will not be sent to other provider offices

- 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.
- 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.
- 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 medical providers office.
- I understand that there may be a charge for obtaining the requested information. Information on the charge amount can be obtained by contacting the medical records staff.
- I understand that a copy of this document is just as valid as the original document.
- I understand that this authorization will expire in 90 days after signing unless an earlier date is specified here: _____

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

_____ _____
(Home address, City, State, Zip Code) (Primary Phone Number)