Palmetto Pediatrics, PA
2781 Tricom Street
Charleston, SC 29406
843-797-5600

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

Street Address _____ **Phone Number** _____

City, State and Zip Code _____ **Social Security Number** _____

☐ I authorize Palmetto Pediatrics to **OBTAIN** my medical records **from:**
☐ I authorize Palmetto Pediatrics to **RELEASE** my medical records **to:**

Including all medical records pertaining to my care and **AUTHORIZE RELEASE OF INFORMATION** RELATED to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immuno-deficiency) Infection, psychiatric care, psychological assessment and treatment for alcohol and/or drug abuse.

Physician or Practice Name _____

Street Address _____

City, State and Zip Code _____

Physician or Practice Phone Number _____

Information Requested:

☐ **All Records**

☐ **Specific Date of Service _____**

☐ **Financial Information Only**

******Please Specify if records are to be mailed or picked up******

☐ **Picked up** ☐ **Mailed**

Signature of Patient or Legal Guardian if under 18 _____ **Date Signed** _____

Witness _____ **Date Signed** _____

Is this a permanent transfer? ☐ **Yes** ☐ **No**

Reason for Request:
- ☐ **Moving**
- ☐ **Change of Insurance**
- ☐ **Medical Needs not met by Physicians**
- ☐ **Excessive wait time for appointments**
- **Other**_____

Note: The Charge for this service is $15.00 per person. Patients will be charged for a personal copy or for the transfer of their records.

Fees charged are in accordance with Physicians Patients Medical Records Act SC Code Ann. 44-115-80