Georgetown Internists and Pediatricians dba

Pawleys Pediatrics and Adult Medicine

Phone 843-314-1314 Fax 843-314-1308

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Expires upon one time release

I authorize: _____Phone_____ Fax:_____
to release medical information regarding:
Patient Information: Name: _____DOB:_____

Address: _____

Social Security #:_____ Telephone #:_____

Covering the period(s) of treatment from _____ to _____

At my request the following information may be released: (check below)

___ Entire Medical Record	___ Radiology Reports	___ Pathology Reports
___ History and Physical	___ Operative Reports	___ Consultation Reports
___ Discharge Summary	___ Laboratory Reports	___ Progress Notes
___ Immunization Record	___ Other: (please specify):_____	

Types of Access Requested: _____Copies of the record _____ On-site record review by patient

Purpose of Disclosure: ☐ Transfer of Primary Care ☐ Continuity of Care ☐ Legal ☐ Insurance

☐ School or Daycare ☐ Subpoena ☐ DSS ☐ Other, explain: _____

☐ D/C ☐ Personal Use ☐ Foster Care

Note:Over the counter or personal use *fees* are payable in advance with *cash or certified check and picture ID !*

Entity or person who will receive the information: **How you want to receive:** (check below)
___ Pick up ___ Mail ___ Fax ___ Email (***must have additional email encryption waiver signed***)

Name:_____ Telephone #: _____

Address: _____ Fax #: _____

City: _____ State: _____ Zip: _____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that released information may include a communicable disease diagnosis such as HIV.

Signature_____/_____/_____
Patient/Parent/Guardian Relationship Date

Office Use Only: _____ Confirmation of signature of relationship to patient
_____ Confirmation of signature on file
_____ Power of Attorney or Legal Documentation Attached