Georgetown Internists and Pediatricians dba
PAWLEYS PEDIATRICS AND ADULT MEDICINE
64 Business Center Drive, Pawleys Island, S.C. 29585
Phone: 843-314-1314 Fax: 843-314-1308

Authorization for Release of Health Information – Medical Record Release

Option required: **□ Expires upon one time release** **□ Expires by written request only**

I authorize my previous healthcare provider (name)________________________________

Phone____________________Fax______________________ to release requested medical information regarding:

My Name____**Date of Birth**________________

Address____Phone________________

City________________________State________Zip____________SSN________________

Covering the period(s) of treatment from______________________to______________________

Please release the following information: (check below)

□ Progress Notes (last 2 only) □ Colonoscopy □ Immunization Record
□ Last Wellness Exam □ Mammogram
□ Most recent labs (last year) □ DEXA/Bone Density
□ Other (please specify)____

Type of Access Requested: □ Copies of the record □ On-site record review by patient

Purpose of Disclosure: □ Transfer of Primary Care to Pawleys Pediatrics and Adult Medicine
□ Continuity of Care □ Personal Use

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 requested information:

Georgetown Internists & Pediatricians dba
Pawleys Pediatrics and Adult Medicine
64 Business Center Drive Pawleys Island, SC 29585
Phone: 843-314-1314 Fax: 843-314-1308

Pawleys Pediatrics and Adult Medicine will only accept Medical Records from patients and/or healthcare facilities in hard copy paper format, via fax, and/or electronically. Medical Records received by Pawleys Pediatrics and Adult Medicine are incompatible in the following formats: USB/Thumb Drives, Flash Drives, Hard Drives, CD-ROMs, and DVDs.

Please send my health information via: (check one) □ Pick up □ Mail □ Fax □ Email

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/AIDS.

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Sign here (Patient or Authorized Person) Relationship to Patient Date

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