Release of Medical Records

To From: Ballentine Pediatrics 11134 Broad River Rd Suite D Irmo, SC 29063
Office 803-732-0920 Fax 803-227-2759

To From: Facility Name____

Address____

Phone__________________________ Fax_________________________

Please release requested medical information for the following patient(s):

Name____DOB__________________

Name____DOB__________________

Name____DOB__________________

Name____DOB__________________

Name____DOB__________________

Purpose of the request: To obtain the patient's medical history for medical treatment, unless otherwise noted: ____

Information to be released: Complete medical records including immunization records__ _____

____

Preferred Delivery: □ Mail Record(s) □ Patient Pick Up □ Fax to Provider/Facility

This authorization will expire One (1) year from the date signed below unless otherwise specified here:______________________

- I understand that the requested medical information may contain information regarding substance abuse, psychiatric treatment, or communicable diseases and this information will be released as part of my medical record.
- I understand that information used or disclosed in regards to this authorization may be subject to re-disclosure and no longer protected by HIPAA.
- I understand that this authorization may be revoked by me, in writing, at any time, and that revocation does not apply to information already released.
- I understand that refusal to sign this authorization cannot be used as a reason for denial of services or benefits
- I understand that Ballentine Pediatrics charges a fee for copying medical records as allowed by federal and state laws and that this fee must be paid before the records can be copied.
- I understand that it may take up to 30 days for medical records to be released.

Signature____Date______________

Address____Phone_____________

Relationship to patient____