Sweetgrass Pediatrics

Authorization for Release of Medical Information

_____ _____ _____

Patient Name | Date of Birth | Social Security Number

_____ _____

Street Address | City | State | Zip | Telephone Number

☐ I authorize Sweetgrass Pediatrics to obtain information from:

_____ _____

Physician/Practice name | Physician/Practice Phone Number

_____

Physician/Practice Fax Number

Information requested: ☐ All Records ☐ Shot Record ☐ Specific Date(s) of service _____

Please forward all requested information to Sweetgrass Pediatrics (please circle location)

2713 Dantzler Drive
North Charleston SC 29406
Ph: 843-764-1722
Fax: 843-764-1788

748 Orangeburg Road
Summerville SC 29483
Ph: 843-832-8606
Fax: 843-285-7272

401 N. Live Oak Drive
Moncks Corner SC 29461
Ph: 843-761-2910
Fax: 843-761-0982

The transfer of medical records shall occur by: ☐ Mail ☐ Pick up from office ☐ Fax _____

☐ I authorize Sweetgrass Pediatrics to disclose/release information to:

_____ _____

Physician/Practice name | Physician/Practice phone number

_____

Physician /Practice fax number

Information requested: ☐ All Records ☐ Shot Record ☐ Specific Date(s) of service _____

☐ Electronic Summary of Health Record (Free of Charge) Email to: _____

Reason for requesting records: ☐ Moving from area ☐ Transferring to another practice ☐ Other

The transfer of medical records shall occur by: ☐ Mail ☐ Pick up from office ☐ Fax _____

_____ _____

Signature of parent or legal guardian | Date

**Note: The charge for this service is $15.00 per person for *OUTGOING RECORDS* only. Patients will be charged for a personal copy or for the transfer of their records, as stated in the Financial Agreement signed by all patients. Fees charged are in accordance with Physicians Patients Medical Records Act SC Code Ann. 44-115-80.

**I understand that any and all information may be released, including but not limited to mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records, and/or HIV test results, if any, except as specifically listed above. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

Unless otherwise revoked, **this authorization will expire on the following date**, event, or condition: _____.

**** For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both patient's treating physician and the patient sign the authorization form before information may be released. It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain records containing HIV test results. **