Rev. 8.30.17

Sweetgrass Pediatrics

For Office Use Only	
Received:	
Paid:	
Sent:	

Authorization for Release of Medical Information

Patient Full Name: _____ Date of Birth: _____

Street Address: _____ Social Security #: _____

City, State, Zip: _____ Telephone Number: _____

I_____authorize Sweetgrass Pediatrics to **obtain information from**:
(Print Parent/Guardian Name)

Physician/Practice Name	Phone Number	Fax Number

City, State, Zip	Email Address

Please forward all requested information to Sweetgrass Pediatrics (mark the location where your child will be seen)

- ☐ 2713 Dantzler Drive North Charleston, SC 29406
- ☐ 748 Orangeburg Road Summerville, SC 29483
- ☐ 401 N. Live Oak Drive Moncks Corner, SC 29461
- ☐ 12 Farmfield Avenue Suite F Charleston, SC 29407
- ☐ 2016 1st Avenue Summerville, SC 29486
- ☐ 1115 Professional Lane Mt. Pleasant, SC 29466

Phone: 843-873-4545

Email: records@sweetgrasspediatrics.com

Information Requested (circle one)

All Records Shot Records

Specific Date(s) of service:

From_____ To_____

I_____authorize Sweetgrass Pediatrics to **disclose/release information to:**
(Print Parent/Guardian Name)

Physician/Practice Name	Phone Number	Fax Number

City, State, Zip	Email Address

INFORMATION REQUESTED(circle): All records Shot records

Specific Date(s) of service: From_____ To_____

REASON FOR REQUESTING RECORDS(circle): Moving from area Transferring to another practice Other

The transfer of medical records shall occur by: Mail Fax: _____

Email: _____ Pick up from office location: _____

Signature of Parent or Legal Guardian	Date

**Note: The charge for this service is $15.00 per person for OUTGOING PAPER 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 undertand 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 one year from the signature date above.

****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.****