Sweetgrass Pediatrics

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 (check one)

☐ All Records ☐ Shot Records

Specific Date(s) of service:

From_____ To_____

I, _____ authorize Sweetgrass Pediatrics to RELEASE information to:
(Print Parent/Guardian Name)

_____ _____ _____
Name Phone Number Fax Number

_____ _____
City, State, Zip Email Address

INFORMATION REQUESTED (circle): All Sweetgrass Records Shot Records Other: _____

Specific Date(s) of service: From_____ To_____ All Dates of Service

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

Please **CIRCLE** the method of delivery: Mail Fax Email _____

Pick up from office location: _____

CD (mail or pick up)

_____ _____
Signature of Parent or Legal Guardian Date

**Note: There will be a $15.00 per person for email/faxed records, $25.00 charge for a CD or paper copy of records, patient portal records are free of charge . 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.****