Outgoing Medical Record Release Form

Patient Name: _____ **DOB:** _____

Medical Records From: (check one) ☐ SouthernMED ☐ Sweetgrass Pediatrics

Medical Records to:

_____ _____

Name of Office/Individual to receive records | Phone Number

_____ _____

Address | City, State, Zip Code

_____

Fax Number

How would you like to receive them?

(choose one) ◯ mailed ◯ picked up at office ◯ faxed

Records requested:

◯ Immunization Record and last 3 office visits (no charge)

◯ Complete Medical Record **(*may be subject to charge*)**

◯ Other (Please Specify) _____

Purpose of Disclosure: _____

I authorize the release of medical information to another provider/facility as deemed necessary for my treatment. I further authorize SouthernMED & Sweetgrass Pediatrics to obtain medical information from another provider/facility as deemed necessary in the course of my treatment. This authorization may be revoked by me, in writing, at any time. Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by HIPAA. My health care and payment for my health care will not be affected by refusing to sign this form. I understand that I may see and copy the information described on this form as requested. **I understand there may be a fee for copying medical records as allowed by federal and state law. I understand that it may take 30 days for medical records to be released and that SouthernMED and Sweetgrass Pediatrics may withhold records until the medical record fee is collected.**

_____ _____

Printed Name of Requestor | Relationship to patient

_____ _____

Patient/Parent/Guardian Signature | Date

Address: _____

Telephone Number: _____ Rev. 2.2025

This release expires 1 year from signature date above unless specified otherwise in writing.

Please return form for processing to any SouthernMED or Sweetgrass Pediatrics front desk or fax to 803-520-5972, attn: Records