neighbors
PEDIATRICS

1871 Savage Rd, Charleston, SC 29407
105 Springhall Rd, Goose Creek, SC 29445
1818 Remount Rd, Hanahan, SC 29410
Phone: 843-766-6308 Fax: 866-533-4473

Authorization for Release of Protected Health Information

PLEASE PRINT CLEARLY AND COMPLETELY

Patient Full Legal Name: _____ Date of Birth: _____

Street Address: _____ Social Security #: _____

City, State, Zip: _____ Best Contact #: (_____) _____

Email Address: _____ May we leave a message at this number: ☐Yes ☐ No

RELEASE INFORMATION FROM:

Neighbors Pediatrics
Name of Facility or Practice

1871 Savage Road, Charleston, SC 29407
City, State, Zip

843-766-6308 Phone Number
866-533-4473 Fax Number

RELEASE INFORMATION TO:

_____
Name of Facility, Person or Company

_____
City, State, Zip

_____
Phone Number Fax Number

PURPOSE OF RELEASE (check reason): ☐ Request of Individual/Personal Use ☐ Continued Patient Care ☐ Relocating
☐ Legal Purpose ☐Dissatisfaction with practice or provider

DATES OF TREATMENT OR DATE RANGE OF RECORDS TO BE RELEASED: From _____ **To** _____

PHYSICIAN PRACTICE INFORMATION TO BE RELEASED (check all that apply):
☐ Office/Clinic Summary (may include most recent office visits, physical exam, consults, and diagnostic test results)
☐ Progress Notes
☐ Laboratory Reports
☐ Radiology Reports
☐ Other: _____
☐ Entire Record (not including psychotherapy notes)

Fees May Apply. Requests for more than ten pages will be processed by our copy service who will contact you about charges that may apply pursuant to SC Code Section 44-115-80.

FORMAT
☐ Paper copy
We do not have the capabilities for email, cd's, or jump drives with patient records.

DELIVERY METHOD (check one)
☐ Reg.US Mail
☐ Pick-up
☐ Fax, **where permitted**

PATIENT'S RIGHTS – I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetics, HIV/AIDS, and other sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- Plantation Pediatrics will not share or use my health information without my permission other than by ways listed in Neighbors Pediatrics Notice of Privacy Practices or as required by law. The Notice of Privacy Practices are available by request.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless an earlier date or event is written here: _____

Print Name: _____ **Parent Signature:** _____ **Date:** ____/_____/____

NOTE: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Check relationship/authority if signature is not that of the patient (written proof may be requested):
☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse
☐ Parent ☐ Adult Child ☐ Affidavit/ Next of Kin ☐ Other: _____