West Ashley: 1871 Savage Road Charleston, S.C. 29407
Goose Creek: 105 Springhall Drive Goose Creek, S.C. 29445
Hanahan / North Charleston: 1818 Remount Road Hanahan, SC 29410

Phone: (843) 766-6308 Fax: 866-533-4473

Authorization for Release of Protected Health Information

Patient Full Name: ______________________	Date of Birth: ______________________
Street Address: ______________________	SSN: ______________________
City, State, Zip: ______________________	Best Contact #: ______________________
E-mail Address: ______________________	May we leave a message at this number? ☐Yes ☐No
RELEASE INFORMATION FROM: **Neighbors Pediatrics**	**RELEASE INFORMATION TO:**
Name of Facility, Person, or Company **1871 Savage Road, Charleston, SC 29407**	Name of Facility, Person, or Company
City, State, Zip **843-766-6308** **866-533-4473**	City, State, Zip
Phone Number Fax Number	Phone Number Fax Number

PURPOSE OF RELEASE: (Please select reason below)

☐Individual/Personal Use ☐Continued Patient Care ☐Relocation ☐Legal ☐Dissatisfaction with practice or provider

DATES OF TREATMENT OR DATE RANGE OF RECORDS TO BE RELEASED: From ______________________To ______________________ or ☐ All

PHYSICIAN PRACTICE INFORMATION TO BE RELEASED: (Check all that apply)

☐Office/Clinic Summary (may include recent office visits, physical exam, consults, and diagnostic test results) Progress
☐Notes
☐Laboratory Reports Radiology
☐Reports
☐Other: ____
☐Entire Records (not including psychotherapy notes)

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

FORMAT	**DELIVERY METHOD** (check one)
☐Paper copy ☐Electronic (Secure Email or USB) We have limited capabilities for electronic transfers. We will contact you for details.	☐Reg. US Mail (Out of State only) ☐Pick-up ☐Fax, where permitted ☐Electronic (Secure E-mail or USB).

PATIENT 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.
- Neighbors Pediatrics will not share or use my health information without my permission other than in ways listed in Neighbors Pediatrics Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is 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/Legal Gurdian/Patient Signature: Date:

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. If signature is not that of patients, written proof of relationship/authority will be required.

☐ Healthcare Agent/POA	☐ Guardian	☐Executor/Administrator/Attorney in Fact	☐ Spouse
☐ Parent	☐ Adult Child	☐ Affidavit/Next of Kin	☐ Other:____________