



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: _____ Street Address: _____ City, State, Zip: _____ E-mail Address: _____	Date of Birth: _____ SSN: _____ Best Contact #: _____ May we leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>RELEASE INFORMATION FROM:</b>	<b>RELEASE INFORMATION TO:</b>
Name of Facility, Person, or Company	<b>Neighbors Pediatrics</b> Name of Facility, Person, or Company
City, State, Zip	<b>1871 Savage Road, Charleston, SC 29407</b> City, State, Zip
Phone Number                      Fax Number	<b>843-766-6308                      866-533-4473</b> 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.

<b>FORMAT</b> <input type="checkbox"/> Paper copy <input type="checkbox"/> Electronic (Secure Email or USB) We have limited capabilities for electronic transfers. We will contact you for details.	<b>DELIVERY METHOD</b> (check one) <input type="checkbox"/> Reg. US Mail (Out of State only) <input type="checkbox"/> Pick-up <input type="checkbox"/> Fax, where permitted <input type="checkbox"/> Electronic (Secure E-mail or USB).
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**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.		
<input type="checkbox"/> Healthcare Agent/POA	<input type="checkbox"/> Guardian	<input type="checkbox"/> Executor/Administrator/Attorney in Fact
<input type="checkbox"/> Parent	<input type="checkbox"/> Adult Child	<input type="checkbox"/> Affidavit/Next of Kin <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____