# Incoming Medical Record Release Form

While medical records are not required to become a patient at our practice, having them is helpful in providing the best possible care for your child. Please complete the form below if you wish to have prior records transferred to our office.

**Patient Name:** _____ **DOB:** _____

**Medical Records From:**

_____
Name of Office

_____
Phone Number

_____
Fax Number

**Medical Records To:**

SouthernMED Pediatrics
2214 Old Cherokee Road
Lexington, SC 29072

Phone (803) 520-9380
Fax (803) 520-5972

**Records requested: Complete Medical Record, birth to present**

I authorize SouthernMED 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 that it may take 30 days for medical records to be released.

_____ _____
Printed Name of Requestor Relationship to patient

_____ _____
Patient/Parent/Guardian Signature Date

_____
Telephone Number