Outgoing Medical Record Release Form

Patient Name: _____ DOB: _____

Medical Records From: SouthernMED Pediatrics

Medical Records to: (choose one)

◯ mailed/faxed

◯ published to portal
(download available for 7 days after request fulfilled)

◯ picked up at Central Services office
(2214 Old Cherokee Road, Lexington, SC 29072)

_____
Name of Office/Individual to receive records

_____
Address

_____
City, State, Zip Code

_____
Phone Number

_____
Fax Number

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 *Southern*MED Pediatrics, LLC 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 anytime. 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 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. 12.2024

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