Outgoing Medical Record Release Form

Patient Name: _____ DOB: _____

Medical Records From:

SouthernMED Pediatrics
2214 Old Cherokee Road
Lexington, SC 29072

Medical Records: (circle one) mailed/faxed to
picked up by
emailed to

_____
Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number

_____
Fax Number

_____
Email address

(SOUTHERNMED DOES NOT RECOMMEND EMAILING PATIENT INFORMATION DUE TO THE POTENTIAL INSECURE NATURE OF THE RECIPIENT'S EMAIL DOMAIN. BY SIGNING BELOW AND CHOOSING TO HAVE RECORDS EMAILED, YOU ARE AWARE OF THIS POTENTIALLY INSECURE METHOD OF COMMUNICATION.)

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: _____

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