AUTHORIZATION TO RELEASE HEALTH INFORMATION FROM PEDIATRIC ASSOCIATES

PATIENT INFORMATION

NAME OF CHILD:____Date of Birth: ______________

ADDRESS: ____

City,State,Zip Code____________________________________Phone Number____________________

NAME AND ADDRESS OF HEALTHCARE PROVDER ATUHORIZED TO RELEASE INFORMATION:

PEDIATRIC ASSOCIATES OF KERSHAW COUNTY, PA
1346 Haile Street
Camden, South Carolina 29020
Office (803) 432-1931 Fax (803) 432-1176

FORWARD INFORMATION TO:

Medical Office Name:____

Address:____

City,State,Zip Code:____

Phone Number:__________________________Fax Number:_________________________________

THE INFORMATION BELOW WILL BE USED FOR PATIENT CARE---PLEASE RELEASE ALL MEDICAL RECORDS

This authorization shall be in effect until the information has been forwarded as requested.

RIGHT OF THE PATIENT

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to:

PEDIATRIC ASSOCIATES OF KERSHAW COUNTY, PA 1346 Haile Street Camden, South Carolina 29020

SIGNATURE OF PATIENT OR
REPRESENTATIVE____DATE______________

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