Luke Bonnett, MD Jerri Lynn Shealy, MD Kimberly Bolen, MD Julie Edwards, APRN Jay Johnson, APRN

Authorization for Release of Protected Health Information:

TO FROM (Circle One) Chapin Pediatrics 723 Chapin Road Chapin, SC 29036

Phone (803) 932-2200 Fax (803) 932-2225

TO FROM (Circle One) Name of Facility _____

Address _____

Phone _____ Fax _____

Please release records for the following patients:

1._____Date of Birth_____

2._____Date of Birth_____

3._____Date of Birth_____

4._____Date of Birth_____

Information to be released (Check all that apply): □ All Records □ Office Notes

□Immunization Records □Labs/X-Ray Report □ ER/Hospital Records

□Other Pertinent Information _____

1) I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable disease, this information will be released as part of my record.
2) I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
3) I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released.
4) I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Chapin Pediatrics.
5) I understand that there may be a fee for obtaining the requested information. Information on the fee can be obtained by contacting the medical records department.
6) I understand that a copy of fax of this document is just as valid as the original document.
7) I understand this authorization will expire 90 days after signed unless another date is specified here _____.

Information Concerning Responsible Party

Name_____Relationship to Patient_____

Address_____City, State, Zip_____

Home Phone Number_____Cell Phone Number_____

Reason for Transfer_____

Signature_____Date_____