



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 Chapin Pediatrics 723 Chapin Road Chapin, SC 29036
(Circle One)
Phone (803) 932-2200 Fax (803) 932-2225

TO FROM Name of Facility _____
(Circle One)
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):

- Immunization Records Labs/X-Ray Report All Records Office Notes
- Other Pertinent Information _____ ER/Hospital Records

- 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 _____