

Sandhills Pediatric & Adolescent Clinic

1749 Marshall Street (DT)
Columbia, SC 29203
(803) 540-2877
Fax: (803) 540-2877

7941 Broad River Rd
Irmo, SC 29063
(803) 407-0704
Fax: (803) 407-2529

110 Summit Centre Dr (NE)
Columbia, SC 29229
(803) 744-9000
Fax: (803) 744-9008

101 Sum Mor Drive
West Cola, SC 29169
(803) 796-9200
Fax: (803) 796-9226

4568 Sunset Blvd
Lexington, SC 29072
(803) 520-5144
Fax: (803) 520-5150

Authorization for Release of Protected Health Information Medical Records To:

Medical Records From:

Clinic: _____

Clinic: Sandhills Pediatrics
Please Circle Location:

Address: _____

Downtown Irmo Northeast

City, State, Zip: _____

West Cola Lexington

Phone: _____

Fax: _____

Please Release Records on the Following Patient:

Name: _____ DOB: _____

Information to be Released: (Please Check All That Apply)

No charge: Last Well Visit, Health Information Summary (including medication list), and Immunization Record

All medical records - Records are limited to the last 2 years of information, **unless otherwise specified here**

Psychiatric/Psychological evaluation notes (patients 13 years and older must consent to release if the parent was not present for the appointment)

Itemized Statement (no charge)

Limited records including the dates of service specified here: _____

I understand that there may be a charge for obtaining the requested information _____ (Please initial)

Purpose of Release: _____ 1.) I understand that if my

records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, 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. Revocations should be sent to the address noted on the top of this form.

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.

5.) I understand that a copy or FAX of this document is just as valid as the original document.

6.) I understand that this authorization will expire in 12 months after signed unless an earlier date is specified here:
(please initial) _____

(Printed Name of Patient or
Authorized Person)

(Signature of Patient or Authorized
Person)

(Relationship to Patient)

(Date)

(Home Address, City, State, Zip)

(Home Phone #)

(Cell/Work Phone #)

Provider Use Only:

Verification Completed By (staff initials): _____ Date: _____

Revised: 09/12/2022