Sandhills Pediatric & Adolescent Clinic

1749 Marshall Street
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
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:

Clinic: **Sandhills Pediatrics**
Please Circle Location:

Downtown **Irmo** **Northeast**

West Cola **Lexington**

Medical Records From:

Clinic:_____

Address:_____

City, State, Zip: _____

Phone:_____

Fax:_____

Please Release Records on the Following Patient:

Name:_____DOB:_____

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

__All medical records (requested for all new patients)
__Last Well Visit, Health Information Summary (including medication list), and Immunization Record
__Psychiatric/Psychological evaluation notes (patients 13 years and older must consent to release if the parent was not present for the appointment)
__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: 09/16/2022