

GRAND STRAND PEDIATRICS & ADOLESCENT MEDICINE, P.A.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize GRAND STRAND PEDIATRICS & ADOLESCENT MEDICINE, P.A. to Use or Disclose my Protected Health information as described below. I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

***** PLEASE MAIL ANY MEDICAL RECORDS OVER 25 PAGES *****

Patient Name _____

First Middle Last

Address _____

Street City State ZipCode

Phone# _____ DOB _____ Gender: (M) _____ (F) _____

Name of Person/Facility authorized to RELEASE the information _____

Address: _____ Telephone: _____ Fax: _____

Name of Person/Facility to RECEIVE the information :
Phone: 843-650-7000 Fax: -843-650-0773

Grand Strand Pediatrics
1120 Glens Bay Road
Surfside Beach, SC 29575

Purpose of Disclosure: _____

Dates of Treatment: _____

INFORMATION TO BE USED/DISCLOSED-Please check those that apply.

- Consultation Summary Discharge Summary Entire Medical Record Pathology Report
 History & Physical Immunization Records Laboratory Report Operative Report
 Progress Report Radiology Report Other (specify) _____

I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, communicable disease including HIV/AIDS this information will be included as part of my medical record to the above named person/facility.

This office may not condition treatment, payment, enrollment, or eligibility for benefits on signing this authorization. This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative provided that the cancellation is made in writing except to the extent that: (1) the Facility has already acted on your request prior to receiving the request to cancel the authorization or (2) If the authorization was given to release records to your insurance company in order to obtain insurance coverage. This authorization will automatically expire in 90 days unless otherwise stated. Expiration Date _____.

Signature of Patient or Legally Qualified Representative _____ DOB: _____

Relationship to Patient _____

Printed Name _____ Date: _____