Sea Island Pediatrics, P.A
2403 Allison Road
Beaufort, SC 29902
Phone Number: (843) 524-1078 Fax (843) 524-1137
Timothy E Keane, D.O., F.A.A.P. Karen L. Keane, D.O., F.A.A.P. Nicole Broerman, M.D. F.A.A.P.

RELEASE OF MEDICAL RECORDS REQUEST

Patient:______________________________________ Date of Birth:__________________
Social Security Number:_______________________

I authorize Sea Island Pediatrics, P.A. to receive/release information on the above named individual.

The type of information to be released is as follows:

- ☐ Office Notes
- ☐ List of Allergies
- ☐ Nurse Notes
- ☐ Immunization Record
- ☐ Laboratory Results
- ☐ Radiology Reports
- ☐ Entire Record
- ☐ Other__________

I understand this information may include reference to (check all that apply):

- ☐ Psychiatric/Psychological Care
- ☐ Sexual Assault
- ☐ Drug or Alcohol Abuse
- ☐ Results of test for all infectious diseases including HIV/AIDS

I authorize the disclosure of this information via (check preferred method):

- ☐ Mail
- ☐ Fax
- ☐ Other__________________

The information is to be released from:______________________________________
Street Address:______________________City:______________State:______Zip Code:__________
Phone Number:__________________________Fax Number:____________________

Purpose of the Release is:______________________________________

I understand that I have a right to cancel/revoke this authorization at any time. I understand that if I cancel/revoke this authorization I must do so in writing and present my written cancellation/revocation to Medical Records. I understand that the cancellation/revocation will not apply to information, which has already been released in response to this authorization as stated in the Notice of Privacy Practice. Unless otherwise canceled/revoked this authorization will expire 90 days from this date.

I understand that a reasonable, cost-based fee for copies of protected health information and postage fees will be charged.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this from to receive treatment. I understand I may review and/or copy the information to be disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person/organization receiving the information. If I have questions about the disclosure or use of my protected health information, I may contact Sea Island Pediatrics, P.A. at (843) 524-1078.

I understand I will be given a copy of this authorization.

______________________________________ ____________________
Signature of Patient or Legal Guardian/Representative Date

____
Printed Name of Patient or Legal Guardian/Representative

______________________________________ ____________________
Relationship to Patient, if signed by Legal Guardian/Representative Witness Signature

Description of Patient Representative's Authority (why patient is not signing):____________________
To contact Medical Records in writing the address is: 2403 Allison Road, Beaufort, SC 29902, Attention Medical Records, Phone Number (843) 524-1078.