PALMETTO AND SPECIALTY PRIMARY CARE PHYSICIANS

Internal Use Only
Account Number:_____
Date ROI Received:_____
Name & Title Verified ROI & ID_____
Date Released:_____
Name & title Processed ROI:

Authorization for Release of Protected Health Information [PHI]

PLEASE PRINT CLEARLY AND COMPLETELY

Patient Full Legal Name: _____	**Date of Birth:** _____
Street Address: _____	**Social Security#:** _____
City, State Zip: _____	**Phone #** (___)_____
Email Address: _____	**May we leave a message at this number:** ☐Yes ☐No
RELEASE INFORMATION FROM: **Name:**_____ **Address:**_____ _____ **Phone Number** **Fax Number**	**RELEASE INFORMATION TO:** **Name:**_____ Address:_____ _____ **Phone Number** **Fax Number**

PURPOSE OF RELEASE (check reason): ☐Personal ☐Medical/Continuity of Care ☐Insurance ☐Legal ☐Transfer:

DATES OF TREATMENT TO BE RELEASED: From_____ **To**_____

INFORMATION TO BE RELEASED (check all that apply): ☐Patient Identification ☐EKG ☐Cardiac Reports ☐Pathology Reports ☐Office Notes/MD Dictation ☐Radiology Images Type($5 for CD)_____	☐Physical Therapy Records ☐Billing Statements ☐Laboratory Reports ☐Radiology Reports ☐Occupational Therapy Records ☐Pulmonary Function Test Reports ☐Other:_____
METHOD OF DELIVERY: ☐Fax ☐US Mail	☐Electronic (email)_____

PATIENT'S RIGHTS - I UNDERSTAND THAT:

- I can cancel this permission at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetics, HIV/AIDS, and other sexually transmitted diseases.
- Once my PHI is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- PPCP will not share or use my PHI without permission other than by ways listed in PPCP Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at www.palmettoprimarycare.com
- A fee may be charged for providing the PHI. Request for more than ten pages will be processed by our copying service who will contact you about charges that may apply pursuant to SC Code Section 44-115-80.
- I have a right to receive a copy of this form upon request

This permission expires one year after the date of my signature unless an earlier date or event is written here:_____

Print Name:_____ **Patient Signature:**_____ **Date:**____/_____/_____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Check relationship/authority if signature is not that of the patient (written proof maybe requested):

☐Healthcare Agent/POA ☐Guardian ☐Executor/Administrator/Attorney in Fact ☐Spouse
☐Parent ☐Adult Child ☐Affidavit/Next of Kin ☐Other:_____

RETURN COMPLETED FORM IN PERSON, BY MAIL OR FAX WITH A COPY OF YOUR PHOTO I.D.

Palmetto Primary Care Physicians Medical Record Department, 2500 Elms Center Rd. North Charleston, SC 29406
Phone: 843-572-7727, #3 Fax: 843-376-2781 email request/questions to: medicalrecords@palmettoprimarycare.com

Request for Medical Records

PHYSICIAN / CONTINUING CARE	NO CHARGE

- Records will be delivered <u>directly</u> to the provider specified by our facility
- Please complete all fields to avoid any delay in delivery of your records

PERSONAL COPY	FEE REQUIRED

- Records will be delivered to the address indicated on your request
- Please complete all fields to avoid any delay in delivery of your records
- For an electronic copy, please provide a legible email address

FEE SCHEDULE

The fees below for reproducing records are allowable pursuant to HIPAA rule 45 C.F.R. § 164.524(c)

ALL REQUESTS

$6.50 fee for individual access request based on average labor for copying
Applicable sales tax

FOR PAPER COPY MAILED REQUESTS ONLY

$0.01 per page mailing cost for paper and toner
$0.15 per envelope mailing cost
Actual Postage

We have partnered with RecordQuest to provide the safest and fastest delivery of your medical records. You will receive an invoice by email, fax or US mail indicating the charges. Please follow instructions indicated on the invoice from RecordQuest for payment and delivery options.

I understand the above fee schedule,

Printed Name	Signature	Date