



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

PLEASE PRINT CLEARLY AND COMPLETELY

Patient Full Legal Name: _____ Street Address: _____ City, State Zip: _____ Email Address: _____	Date of Birth: _____ Social Security#: _____ Best Contact# (____) _____ May we leave a message at this number: <input type="checkbox"/> Yes <input type="checkbox"/> No
RELEASE INFORMATION FROM: _____ Name of Facility or Practice _____ City, State, Zip _____ Phone Number _____ Fax Number _____	RELEASE INFORMATION TO: _____ Name of Facility or Practice _____ Mailing Address: _____ Phone Number: _____ Fax Number: _____
PURPOSE OF RELEASE (check reason): <input type="checkbox"/> Personal <input type="checkbox"/> Medical/Continuity of Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Transfer:	
DATES OF TREATMENT TO BE RELEASED: From _____ To _____	
INFORMATION TO BE RELEASED (check all that apply): <input type="checkbox"/> Patient Identification <input type="checkbox"/> EKG <input type="checkbox"/> Cardiac Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Office Notes/MD Dictation <input type="checkbox"/> Radiology Images Type(May be charged \$5 for CD) _____	<input type="checkbox"/> Physical Therapy Records <input type="checkbox"/> Billing Statements <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Occupational Therapy Records <input type="checkbox"/> Pulmonary Function Test Reports <input type="checkbox"/> Other: _____
FEES MAY APPLY. 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.	
METHOD OF DELIVERY: <input type="checkbox"/> Fax <input type="checkbox"/> US Mail <input type="checkbox"/> Electronic (email) _____	
PATIENT'S RIGHTS- I UNDERSTAND THAT: <ul style="list-style-type: none"> 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 health information 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 health information 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 protected health information. 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): <input type="checkbox"/> Healthcare Agent/POA <input type="checkbox"/> Guardian <input type="checkbox"/> Executor/Administrator/Attorney in Fact <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Adult Child <input type="checkbox"/> Affidavit/Next of Kin <input type="checkbox"/> 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: 843-820-3300 Fax: 843-376-2781	

Request for Medical Records

PHYSICIAN / CONTINUING CARE	NO CHARGE
<ul style="list-style-type: none"> 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. 	

THIRD PARTY REQUESTERS	FEE REQUIRED
FEE SCHEDULE FOR THIRD PARTIES	
<p>The fees below for reproducing records are allowable pursuant to SC ST SEC 44-115-80</p> <p>ALL THIRD PARTY REQUESTS</p> <p style="padding-left: 40px;">\$25.00 Search and retrieval fee \$0.65 per page for pages 1-30 \$0.50 per page for all other pages Maximum fee of \$150 for electronic delivery Maximum fee of \$200 for paper delivery Applicable sales tax</p> <p>FOR MAILED REQUESTS ONLY</p> <p style="padding-left: 40px;">Actual Postage</p>	

PATIENT PERSONAL COPY	FEE REQUIRED
<ul style="list-style-type: none"> Records will be delivered to the address indicated on your authorization. Please complete all fields to avoid any delay in delivery of your records. 	
FEE SCHEDULE FOR PATIENT PERSONAL COPY	
<p>The fees below for reproducing records are allowable pursuant to HIPAA rule 45 C.F.R. § 164.524(c)</p> <p>ALL PATIENT REQUESTS</p> <p style="padding-left: 40px;">\$2.00 fee for reviewing information access request \$0.20 per page fee for compiling and reproducing pages Maximum fee of \$150 for electronic delivery Maximum fee of \$200 for paper delivery Applicable sales tax</p> <p>FOR MAILED REQUESTS ONLY</p> <p style="padding-left: 40px;">\$0.01 per page mailing cost for paper and toner \$0.15 per envelope mailing cost Actual Postage</p>	

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
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