RELEASE OF MEDICAL RECORDS

I request that: ____
(Physician)

____
(Practice)

____
(Address)

____

____

______________________ ______________________
(Telephone) (Fax)

Please release the complete medical records including progress notes, nurse notes, labs/x-rays reports, hospital records, immunizations and any referral/consult notes on the following patient(s) from their birth to present:

Child's Full Name: ______________________________ DOB: ____________

Please send the records to:

Greer Pediatric Center, LLC
111 Memorial Drive
Greer, SC 29650
Phone (864) 848-7005 Fax (864) 848-3666

I understand that the release or transfer of the information specified above to any person or entity not specified above is prohibited.

- I understand that this form does NOT authorize the release of any medical information concerning HIV test results and/or treatments, sexually transmitted diseases, generic testing, psychiatric care, psychological assessment and/or treatment, drug or alcohol abuse testing and/or treatment or pregnancy treatment. Consent to release this information requires a separate form and signature.
- I understand that I may revoke this consent at any time except to the extent that this action has already been taken and that it expires 90 days from the date indicated below.

Parent/Guardian: ________________________________ Date: ___________
Relationship to Patient: ____________________________ (Patient must sign if 18 years or older)