

**Authorization For Release Of Protected Health Information
TO Chapin Pediatrics PA.**



*119 Amicks Ferry Road, Chapin, SC 29036
932.2200, 945.4445, 932.2225 - fax www.chapinpediatrics.com*

I, _____, as a representative for,

(Patient's full name) and whose date of birth is
_____, hereby authorize release of the following health information from:

Name of Physican & Hospital: _____

Street Address: _____

City, State & Zip Code: _____

Office Phone #: _____

to release the following health information to: **Chapin Pediatrics PA.**

Immunization Records Office, ER, and hospital notes

Lab, x-ray, and pathology reports Other pertinent information

Mailing Address:
119 Amicks Ferry Road
Chapin, SC 29036

Please initial below:

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to the facility listed above. I understand that a revocation is not effective to the extent that Chapin Pediatrics, PA has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment at Chapin Pediatrics, PA.

I understand that there may be a charge for obtaining the requested information. Information on the charge can be obtained by contacting the facility listed above.

I understand this authorization shall be in force and effect for 60 days, unless an earlier expiration date is specified here _____.

I understand that a copy or FAX of this document is just as valid as the original.

(Signature of patient representative)

(Date)

Relationship to patient: _____