EXPRESS PEDIATRIC CARE

Medical Records Request

*Authorization for Use of Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Patient Name: ____ Date of Birth: ________________

Information to be released from:

Practice Name: ____

Address: ____

Phone number: __________________________________ Fax: ________________________________

Information to be sent to:

Express Pediatric Care

10 Enterprise Blvd., Ste. 105

Greenville, SC 29615

Phone number: 864-551-2422 Fax number: 864-551-2424

Information to be released:

__ Chart Notes __ Lab Results. __ X-Rays __ Immunization records

__ Specific Information (please specify): __________________________________

Purpose for which disclosure is being made:

__ Change of Provider __Personal

My Rights:

I understand I do not have to sign this form in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this form in writing. I understand that once the health information I have authorized to be disclosed reached the noted recipient, that person or organization may re-disclose it, at which it may no longer be protected under privacy law. Copy of this form is as valid as the original.

Parent/Guardian Name: ____

Parent Guardian Signature: ____

Date: _____________________________