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

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: ☐Yes ☐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): ☐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(May be charged $5 for CD)_____	☐Physical Therapy Records ☐Billing Statements ☐Laboratory Reports ☐Radiology Reports ☐Occupational Therapy Records ☐Pulmonary Function Test Reports ☐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: ☐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 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):

☐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 Fax: 843-376-2781

Request for Medical Records

PHYSICIAN / CONTINUING CARE	NO CHARGE

- Records will be delivered directly 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

The fees below for reproducing records are allowable pursuant to SC ST SEC 44-115-80

ALL THIRD PARTY REQUESTS

$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

FOR MAILED REQUESTS ONLY

Actual Postage

PATIENT PERSONAL COPY	FEE REQUIRED

- 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

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

ALL PATIENT REQUESTS

$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

FOR 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