



448 Old Cherokee Road
Lexington, SC 29072

Medical Records From:

Medical Records To:

Name of Facility

Address

City, State, Zip Code

Phone Number

Fax Number

Name of Facility

Address

City, State, Zip Code

Phone Number

Fax Number

Please release medical record information and/or immunization record information for:

Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____

I am aware that if the medical record has information regarding substance abuse, psychiatric treatment, or communicable diseases, this information may be released.

Records Required/Date of Service: _____ Complete Record _____
Immunization _____ Other (Please Specify) _____
Purpose of Disclosure: _____

I authorize the release of medical information to another provider/facility as deemed necessary for my treatment. I further authorize Lake Murray Pediatrics, LLC to obtain medical information from another provider/facility as deemed necessary in the course of my treatment. This authorization will expire sixty (60) days from the date of signature and may be revoked by me, in writing, at anytime. Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by HIPAA. My health care and payment for my health care will not be affected by refusing to sign this form. I understand that I may see and copy the information described on this form as requested. I understand there is a fee for copying medical records.

Patient/Parent/Guardian Signature **Date**

Address: _____

Telephone Number: (H) _____ (W) _____

Date/Initials Completed: _____ Fee Collected: \$ _____