Charleston Location
830 Pennsylvania Ave, Suite 110
Charleston, WV 25302

South Charleston Pediatrics

(304) 982-7031 (phone)
(304) 766-9450

Hurricane Location
3751 Teays Valley Road
Hurricane, WV 25526

Medical Record Release
(Patient Authorization for Use and Disclosure of Protected Health Information)

Patient(s) Name: _____ **DOB:** _____

_____ _____

_____ _____

Information FROM:_____ **Address:**_____ **Phone #:**_____**Fax#:**_____	**Being Sent TO** **South Charleston Pediatrics** 830 Pennsylvania Ave, Suite 110 Charleston, WV 25302

**********OR**********

Being Sent FROM **South Charleston Pediatrics**	**Information TO:**_____ **Address:**_____ **Phone #:**_____**Fax#:**_____

Reason for transfer of information from South Charleston Pediatrics:

- ☐ Transferring to another physician
- ☐ Other (Please explain):_____

Requested information to be sent:

- ☐ Last Well Child Exam
- ☐ Immunization/Vaccine Record
- ☐ Entire Medical Record* (including all psychological reports & HIV/STD testing)
- ☐ Other: _____

For outgoing medical records, I request that this information be:

- ☐ Mailed to the address above (can only mail medical records to physician practices or to the patient)
- ☐ Charleston office pick up by the patient, guardian or third party designee.
- ☐ Hurricane office pick up by the patient, guardian or third party designee (only last well visits, camp/sports forms and immunization records)

***Entire medical record may only be picked up in the Charleston location**

This authorization will expire on _____. (This must be filled out)

I do not have to sign this authorization in order to receive treatment from South Charleston Pediatrics, PLLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the South Charleston Pediatrics, PLLC Privacy Officer.

_____ _____
Signature & Printed Name of Patient and/or Legal Guardian Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION