COASTAL
PEDIATRIC ASSOCIATES

4975 Lacross Rd Suite 150
North Charleston, SC 29406
P: (843)573-2535 F: (843)573-2534

Medical Records Release Form

Patient Name: ____Date of Birth: _________________

Patient Address: ____ City: ________________________

State: __________ Zip Code: _____________ Patient Phone: (____)____________________________

The undersigned hereby authorizes, ____

Address: ____________________________________ City/State/Zip: ______________________________

Phone: (____)__________________ Fax: (____)_________________ Email: ________________________

To release the below information to: ____

Address: ____________________________________ City/State/Zip: ______________________________

Phone: (____)__________________ Fax: (____)_________________ Email: ________________________

Treatment Date(s) (When were you seen?)	☐ Treatment date from __________ to __________ (be specific) **OR** ☐ All Treatment Dates		
Information to Be Released: (What would you like released?)	☐ Entire Medical Record **OR** ☐ Abstract Information History & Physical, consults, lab & radiology reports, discharge summary, operative/procedure reports, Emergency Department reports, and Occupational/Speech/Physical Therapy reports	☐ Radiology Images ☐ Immunization Records ☐ Medication List ☐ Physician Progress/Visit Notes	☐ Other: _______________ _______________ _______________
Purpose of Release (Why do you need to release the info?)	☐ Continuing Care ☐ Legal ☐ Patient Request ☐ Military	☐ Insurance ☐ Disability ☐ School ☐ Other: ____________________	

I understand that I may REVOKE this release at any time, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first, EXCEPT to the extent that action has been taken thereon. I also understand that, unless I specify otherwise, this release form may authorize release of information related to physical illness, mental illness, and communicable diseases, including but not limited to HIV, AIDS, and/or AIDS related information. I also understand that faxed or photocopies of the release are permissible and if I am requesting copies for self-records there will be a fee as defined in SC State Law Section 44-7-130.

Signature of Patient or Legal Representative if patient is a minor____

Date: ____________________ Relationship to patient: ____