SHOT RECORD RELEASE AUTHORIZATION

_____ _____

(Please Print Patient's Name) (Date of Birth)

_____ _____

(Street Address/ PO Box) (SS Number)

_____ _____

(City, State, Zip Code) (Phone Number)

CONDITIONS AND NOTIFICATIONS:

I hereby authorize the use of disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization is voluntary and that my healthcare and the payment for my healthcare will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and therefore, may be subject to re-discloser. This authorization for release of information expires 12 months from the date of patients (Guardian) signature unless otherwise specified. You may revoke this authorization in writing at any time by notifying Eastside Pediatrics, PA Attn: Office Manager, Eastside Pediatrics, PA, 4501 Old Spartanburg Road, Suite 9, Taylors, SC 29687. However, such notification will not affect any health information to be used or disclosed, consistent with the federal law.
NOTE: There may be a copying fee charged to the patient to cover labor and supplies used to reproduce medical records.
Eastside Pediatrics, PA is authorized to disclose the health information listed above.

INFORMATION RELEASE TO:

_____ _____

(Name of Guardian) (Relationship)

_____ _____

(Signature) (Date)

Brian K. Few, MD Roy A. Mages, MD Jeffery M. Phillips, MD

Tabitha M. Randol, MD Carolyn G. Schultz, MD