THE PEDIATRIC CLINIC, P.A

940 HOLLY ST N.E.
ORANGEBURG, S.C. 29115
(803) 536-2725 or FAX (803) 534-3118

On the Road to a Healthy Life

AUTHORIZATION FOR RELEASE OF INFORMATION REQUESTED BY A COVERED ENTITY FROM ANOTHER COVERED ENTITY

I, ________________________________, hereby authorize _________________________
To disclose the following protected health information to The Pediatric Clinic, PA

Patient Name: _____________________________________ Date of Birth ___________________
Patient Name: _____________________________________ Date of Birth ___________________
Patient Name: _____________________________________ Date of Birth ___________________

The following is a specific description of the health information I authorize to be used or disclosed:

______Discharge Summary ______ Physician Progress Notes _____ Operative Report
_____ History & Physical ______ X-ray Reports ______ Path reports
_____ Consult Reports _____ Lab Reports ______ER reports
Other (please specify) ____

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of The Pediatric Clinic in the following manner:

____
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Expiration of Authorization: This authorization will expire on: _________________________

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to The Privacy Officer at 940 Holly St. N.E., Orangeburg, S.C. 29115. I understand that a revocation is not effective to the extent that The Pediatric Clinic has relied on the use of disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

The Pediatric Clinic will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

____ _______________

Signature of Parent or Guardian Date