AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

If more than 20 pages, mail to: 325 BROAD STREET – STE 100 SUMTER SC 29150

Email: cfp_medical.records@colonialfamilypractice.com Fax: 803-757-4152

Immunization Records Phone: 803-773-5227 Fax: 803-757-4162

PATIENT NAME (PLEASE PRINT)_____DATE OF BIRTH_____

ADDRESS _____ PHONE (____)_____

CITY _____ STATE _____ ZIP _____

AUTHORIZE COLONIAL HEALTHCARE TO (CHECK ONE): ☐ RELEASE RECORDS TO: ☐ OBTAIN RECORDS FROM:

FACILITY/PERSON/SELF_____ PHONE (_____)_____

ADDRESS_____

CITY _____ STATE _____ ZIP _____
FAX (_____)_____EMAIL _____

IF TO SELF(CHECK ONE): ☐ RECORDS ON PAPER ☐ RECORDS ON CD (PDF FORMAT) *****READ NOTICE BELOW FOR FEES*****

I WOULD LIKE TO PICK UP MY RECORDS AT _____ (PREFERRED CFP LOCATION) IF THE ABOVE BOX IS NOT CHECKED, RECORDS WILL PROCESSED VIA RECORDQUEST. IF LOCATION IS LEFT BLANK, RECORDS WILL BE SENT TO OUR MAIN LOCATION AT ADDRESS ABOVE. PLEASE WAIT FOR PHONE CALL TO PICK UP RECORDS.

PLEASE CHECK ALL THAT APPLY. SPECIFY DATES IF APPLICABLE:

- ☐ IMMUNIZATION RECORDS
- ☐ ALL MEDICAL RECORDS
- ☐ OFFICE NOTES _____
- ☐ RADIOLOGY REPORTS _____
- ☐ LAB REPORTS _____
- ☐ IMAGES (PLEASE FWD TO SPECIAL PROCEDURES)
- ☐ OTHER _____

CHECK FOR RELEASE UNDER SPECIAL PROTECTION BYLAWS.

- ☐ DIAGNOSIS/TREATMENT OF AIDS, HIV TESTS
- ☐ DIAGNOSIS/TREATMENT OF DRUGS AND/OR ALCOHOL ABUSE
- ☐ CONSULTATION/TREATMENT FOR MENTAL AND/OR PSYCHOLOGICAL HEALTH CARE

PURPOSE OF RELEASE:

- ☐ SELF
- ☐ TRANSFER/CONT. OF CARE/REFERRAL
- ☐ RELOCATION
- ☐ WORKER'S COMPENSATION/INSURANCE
- ☐ DISABILITY DETERMINATION
- ☐ ARMED FORCES REQUIREMENT
- ☐ LEGAL MATTERS
- ☐ OTHER _____

UNLESS TO A MEDICAL FACILITY, THERE IS A CHARGE FOR RECORDS. *S.C. LAW, ST SEC 44/155-80* REGARDING FEES: PAPER – PAGES 1-30 $0.65 PER PAGE, PAGES 31+ $0.50 PER PAGE (MAX $200.00) $25 FOR CD IN PDF FORMAT.

UNLESS REVOKED/CANCELLED IN WRITING, THIS AUTHORIZATION WILL EXPIRE 1 YEAR FROM TODAY'S DATE OR ON _____. I UNDERSTAND AUTHORIZATION OF THIS FORM IS VOLUNTARY. I UNDERSTAND THE PRACTICE WILL NOT CONDITION TREATMENT OR PAYMENT BASED UPON MY SIGNING THIS AUTHORIZATION. I UNDERSTAND THAT I WILL NOT BE DENIED TREATMENT, PAYMENT, AND ENROLLMENT IN THE HEALTH PLAN, OR ELIGIBILITY FOR BENEFITS FOR REFUSING TO AUTHORIZE DISCLOSURE UNLESS SUCH DENIAL IS PERMITTED UNDER STATE AND FEDERAL LAW. I UNDERSTAND THIS FORM CARRIES WITH IT THE POSSIBILITY OF UNAUTHORIZED DISCLOSURE BY THE ORGANIZATION RECEIVING THE INFORMATION. I UNDERSTAND ALL EMPLOYEES/PHYSICIANS OF COLONIAL HEALTHCARE ARE RELEASED FROM LEGAL LIABILITY FOR RELEASE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED. I UNDERSTAND THE FEES FOR COPIES OF MEDICAL RECORDS ARE PROVIDED BY *S.C. LAW, SC ST SEC 44/115-80.*

_____ _____
SIGNATURE OF PATIENT/LEGAL GUARDIAN/REPRESENTATIVE DATE

_____ _____
PRINT NAME & RELATIONSHIP TO PATIENT IF NECESSARY WITNESS SIGNATURE/DATE

NOTICE:FORM MUST BE COMPLETE TO PROCESS INCOMPLETE FORMS WILL BE REJECTED. PLEASE ALLOW 7-10 BUSINESS DAYS FOR PROCESSING, MAXIMUM OF 30 DAYS. PLEASE DO NOT FAX RECORDS IF MORE THAN 20 PAGES. UPDATED 04/2021.