PATIENT RECORDS ACCESS REQUEST FORM

P.O. Box 3440
Murrells, Inlet, SC 29576
Tel: 843-651-6525
Fax: 843-357-0768

I hereby request a copy of my medical records as detailed below:

☐ Full medical record held by this office
☐ Medical record for the period ________________ through __________________
☐ A specific portion/section of the record as follows:
____

____

____

Reason for request:____

____

If this is the first time you are requesting records of any kind, there will be NO FEE. If you have requested records more than once, there will be a charge, unless otherwise provided by law, of $15.00 service fee and $0.65 per page up to 30 pages, $0.50 per page after 30 pages. Postage is an additional fee if needed. I agree to pay this charge in full at the time I receive the copy of the record.

Patient Name:____________________________________ Date:____________________

Date of Birth:____

Telephone:____

☐ I will pick up my records in the office

☐ I wish to have my records mailed to: _______________________________________

____

☐ I wish to have my records faxed to: _______________________________________

Signature:____ Date:_________________________

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RECORDS RELEASE REQUEST FORM (HIPAA)

1. Patient Information:

Name:____ Date of Birth: ____________________

Address: ____

Social Security Number:______________________________ Telephone: ________________________

2. Release Authorization:

I hereby authorize and request the following:

Provider/Facility OR Carolina OB/GYN

______________________________ PO Box 3440

______________________________ Murrells Inlet, SC 29576

______________________________ Fax: 843-357-0768

Tel: ___________________________

Fax: ___________________________

To disclose the following healthcare records:

___ Complete Health Records ___ Discharge Summary ___ Progress Notes

___ History & Physical Exams ___ Consultation Reports ___ Laboratory Tests

___ X-Ray Reports ___ Scans, Photos, Digital or other images

___ Other (Please Specify) ____

3. Delivery Instructions:

I further authorize the information released in Section 2 to be sent to:

Provider/Facility OR Carolina OB/GYN

______________________________ PO Box 3440

______________________________ Murrells Inlet, SC 29576

______________________________ Fax: 843-357-0768

Tel: ___________________________

Fax: ___________________________

** The facility releasing the information may use their professional judgement as to the method of sending the requested information, by fax, mail, overnight delivery or electronically**

4. Patient Signature

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:__________________________

OR One year from the date signed below, whichever comes first.

In addition, the facility, it's employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized here in,

SIGNATURE:____ DATE:____________________