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**REQUEST FOR MEDICAL RECORDS TO TRANFER IN
\*\*\* If over 40 pages please mail records \*\*\***

Pediatric Associates, P.A. **Choose a Physician**: \_\_\_\_ C. Guy Castles, III, M.D.

2601 Laurel Street Suite 250 \_\_\_\_ Joe B. (Trey) Castles, III, M.D.

Columbia, SC 29204 \_\_\_\_ Shannon W. Easterlin, CPNP Phone: (803) 799-9044

Fax: (803)256-8119
Email: Tweston@pedassoc.com

**Send Records To:** Name of Practice: Pediatric Associates, P.A.

 Address: 2601 Laurel Street, Suite 250

 Columbia, SC 29204

 Phone: 803.799.9044 Fax: 803.256.8119

**Request Records From**: Name of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Please release medical record information for**:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please send the following:** X Entire Record X Immunization Records X Labs X Progress Notes

Birth to Current

 X Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, behavioral or

mental health services, or drug and alcohol abuse.

By signing, I am releasing Pediatric Associates, P.A. from all liability in connection with the release of those records to another party. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that if I fail to specify and expiration date, this authorization will expire in six months form the date of this authorization. I also understand that once this information is disclosed it may be re-disclosed by the recipient, and the information may not be protected by the Federal Privacy Laws and regulations. I understand the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure access to medical treatment.

\_\_\_ My Personal Use (fees apply) \_\_\_\_ Sharing with Another Provider \_\_\_\_Attorney \_\_\_Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient/Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/ Parent/Guardian Printed Name Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship To Patient