Sumter Pediatrics, P.A.

237 CHURCH STREET
SUMTER, SOUTH CAROLINA 29150
(803)775-6311
(803)778-5131fax

JAMES M. DURANT, JR., M.D.
J. MARK MITCHINER, M.D.
JASON B. GRIER, M.D.
HANNA S. RIVERS, F.N.P.

TIMOTHY L. KEY, M.D.
MELISSA W. ARSCOTT, M.D.
MICHELE R. EASLER, M.D.
HEATHER B. BURNS, DNP, APRN

Authorization for Release of Protected Health Information

Child's Name: _____ Date **of Birth**: _____

I hereby authorize information to be released from:
Practice Name: _____
Address: _____
City, State, Zip: _____
Fax Number: _____

To:
Name/Practice Name: _____
Address: _____
City,State,Zip: _____
Fax Number: _____

The type of information to be released is as follows:
(check all appropriate boxes)

☐ **Office visits**
☐ **Lab results**
☐ **X-ray and/or imaging reports**
☐ **Specialist reports**
☐ **Immunization records**
☐ **Entire medical record**

The information I am releasing is intended for the following use:
☐ **My personal records**
☐ **Use by another health care provider**
☐ **Other**_____

I understand that the information in the health records may include information relating to sexually transmitted disease, including HIV. It may also include information about behavioral mental health services, and treatment for alcohol or drug abuse.
I understand that I have the right to revoke this authorization at any time. This must be done in writing. I understand that Sumter Pediatrics P.A. has a privacy policy and that this policy is available for me to review at any time on request. This authorization will expire one year from the date below.

Signature of Parent or Guardian:_____ **Date:**_____

Print Name:_____**Relationship to Patient:**_____

Witness: _____ **Date:** _____