AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
TRANSFER OF RECORDS TO NEW PRACTICE

Patient Name: _____ Date of Birth: _____

Address: _____ SS # _____

_____ Patient# or MR#: _____

Pursuant to S,C, Code Ann. § 44-115-30, I hereby authorize Pee Dee Family Practice and its associated physicians and advanced practice providers, 286 N Ron McNair Blvd, Lake City, SC 29560 (Provider) to disclose and transfer my "protected health information" (PHI) to the location indicated below:

☐ McLeod Primary Care Lake City
241 Kelley Street, Lake City, SC 29560
Phone: 843-519-2399

☐ McLeod Primary and Chronic Care Specialists
101 South Ravenel Street, Suite 300
Florence, South Carolina 29506
Phone: (843) 777-7490

Please Mail Paper chart.

Please provide a complete copy of all my medical records in your possession, including but not limited office notes, vitals, medications, lab results, test results, diagnostics results and any other records relating to my medical treatment and care for the purpose of establishing care with a new provider.

A.) I understand that PHI may include records disclosed by health care providers and facilities that previously provided treatment to me.
B.) I understand that PHI may include information and records protected under Federal Law (such as alcohol and drug abuse treatment) and/or State Law (such as mental health, AIDS or HIV).
C.) I understand I may revoke this Authorization at any time however the revocation will not apply to PHI that has already been used or disclosed pursuant to this authorization. Contact the Privacy Official to initiate the revocation process.
D.) I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy standards.
E.) I understand that this Authorization will expire in 90 days after it is signed unless another date is specified here _____.

I have read and understand this Authorization. I certify that I am the Patient listed above or a person authorized to permit release of records on the Patient's behalf. I hereby release the Provider (as named above) from any liability or damages arising in connection or related to with the use and/or disclosure of my protected health information pursuant to this Authorization.

_____	_____	_____
Print Patient Name	Patient Signature	Date
_____	_____	_____
Authorized Representative	Relationship to Patient	Telephone Number