Request for Medical Records

Pediatric Associates, P.A.
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Columbia, SC 29203
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Choose a Physician:
___ C. Guy Castles, III, M.D.
___ Joe B. (Trey) Castles, III. M.D.
___ David L. Bowen, M.D.
___ Anoosheh Moghbeli, M.D.

Send Records To:

Name of Practice: ____
Address: ____
____
Phone: ___________________ Fax:__________________

Request Records From:

Name of Practice: ____
Address: ____
____
Phone: ___________________ Fax:__________________

Please release medical record information for:

Patient Name: ____ Date of Birth:___________________
Patient Name: ____ Date of Birth:___________________
Patient Name: ____ Date of Birth:___________________

Please send the following: ___ Entire Record ___Immunization Records __Labs ___Progress Notes
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 this form 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.

The information for which I am authorizing disclosure will be used for the following purpose:

___ My Personal Use (fees apply) ____ Sharing with Another Provider ____Attorney
___Other (please specify) ____

____ ____
Patient/Parent/Guardian Signature Date

____ ____
Patient/Parent/Guardian Printed Name Phone number