The Children's Group, P.C.

Joni Ovanna-Budhram, MD / Solomon Budhram, MD

Marian Japitana Bunnell, MD / Haley Jackson, CPNP

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

I give permission to:

Name of Facility: _____

Phone Number: _____ Fax Number: _____

To release information to:

The Children's Group, P.C.

604 N 5th Street

Hartsville, SC 29550

Phone (843) 332-6645 Fax (843) 332-9894

Information to be released:

__Entire Medical Record __Discharge Summary

__Vaccine Record __Radiology Images

__Educational Records __Disciplinary Records

__Psychoeducational Testing __IEP and/or 504 Plan

__Other _____

Reason for release of information:

__ Transfer of Treatment __Coordination of Care __Other

By law, the Children's Group may not use or share my health information without my permission. I can cancel this authorization at any time. I can't cancel consent for information already shared as a result of my permission. I do not have to sign this form. Refusal won't change my ability to get treatment, payment for treatment or benefits. Once my information is sent, it may not be protected by law and someone may be able to share my information with others without my permission. I have read, understand and, upon my request, been given a copy of this form. This is not for use for marketing or research. Authorization expires 90 days after I sign, unless otherwise noted.

Signature _____ Date _____

Relationship to Patient _____