

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION



GENERATIONS
Pediatrics & Internal Medicine

Patient Name (PRINT) _____

DOB _____

Authorization for Disclosure of Medical Information: The privacy of your medical information is important. We will discuss your medical condition with person(s) you designate.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (Check and complete one)

The following family members or other individuals may receive information regarding my medical condition:
Print first and last name(s) _____

OR

Any family member or other individual inquiring about my medical condition may receive information from my provider, EXCEPT the following individuals: *Print first and last name(s)* _____

You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.

NOTE: This designation does not give the above named individuals the right to make health care decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.

Confidential Communication: Please provide phone number(s) where we can reach you:

Home: _____ Work: _____ Mobile Phone: _____ Other _____

Messages: A request for return calls may be left on the following answering machine or voice mail: *(Check all that apply)*

Home Work Mobile Phone I do not authorize

I authorize my medical information to be left on the following answering machine or voice mail: *(Check all that apply)*

Home Work Mobile Phone I do not authorize

If we are unable to reach you or leave a message at the above phone number(s), please indicate with whom we may leave a message for you to call our facility.

Name _____ Phone Number _____
Name _____ Phone Number _____

Note: An automated appointment reminder system may call the number listed in our data base.

Signature: I hereby authorize the disclosure of my medical condition and information as described above.

Patient/Patient's Representative Signature: _____ Date: _____ Time: _____

PRINT Name (if Patient's Representative): _____

Relationship to Patient (if Patient's Representative): _____