Authorization Release Statement

PALMETTO HEALTH

Name of Patient _____ Date of Birth _____

SS# _____ Patient ID# _____

Authorization Release Statement

☐ Yes ☐ No **DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHO?**

Per my request, I hereby authorize Palmetto Health to communicate my medical information and/or billing information to the following individuals:

1. Name _____ Phone# _____

   Relationship _____ Alternate # _____

2. Name _____ Phone # _____

   Relationship _____ Alternate # _____

3. Name _____ Phone # _____

   Relationship _____ Alternate # _____

☐ Yes ☐ No I give permission to leave messages on my answering machine/voice mail. Phone # _____
(I would like test results or appointment information left on my answering machine/voice mail.)

☐ Yes ☐ No I give permission to call my place of employment.

☐ Yes ☐ No I give permission to leave messages on my voice mail at work.

☐ Yes ☐ No I give permission for Palmetto Health to release information to my employer or my school regarding absences or immunizations.

Rights of Patient

I understand that I have the right to revoke this authorization at anytime and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to the Privacy Officer or Administrator. I understand that revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing. This authorization shall be in effect until revoked by the patient.

Signature of patient or personal representative _____ Date _____

Description of personal representative's authority _____

Signature of patient or personal representative _____ Date _____