

PALMETTO FAMILY MEDICINE

109 Barton Creek Court Columbia, SC 29229
803.256.2286 VOICE 803.419.3224 FAX

HIPAA

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Palmetto Family Medicine of Columbia, P.A.'s Notice of Privacy Policies, detailing how my information may be used or disclosed as permitted under federal and state law. I understand the contents of the Notice, and I requested the following restriction(s) concerning the use of my personal medical information:

Authorization for Release of Patient Information

I, _____ / _____ give permission to Palmetto Family Medicine to
(Print Name) & (Print Date of Birth)
disclose the following protected health information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

* We will not release any of your information, including any medical records, account balances or payment history to anyone that is not listed on this form with the exception of your insurance company, other providers and any government agency that may request your information.

Authorization for Medical Insurance Benefits

* Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

* You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

Internal Use Only: If patient or patient's representative refuses to sign acknowledgement of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date): _____ By (name & title): _____

