

PALMETTO FAMILY MEDICINE

109 Barton Creek Court

Columbia, SC 29229

803.256.2286 Voice 803.419.8430 Fax

HIPAA

Authorization for Release of Patient Information

A. What type of medical information can be left on your voice mail?

I, _____ / _____ / _____ give permission to PFM to
(Print Patient's Name) (Date of Birth) (Last 4 digits of SS#)
disclose the following protected health information to meet my request for information & disclosures & uses by leaving a message on my **VOICE MAIL: #** _____

Appointment time Results of tests/x-rays Financial info Rx Info Treatment Info Medical History

B. Who else can have your medical information & what type of information can they have?

I, _____ / _____ / _____ give permission to PFM to
(Print Patient's Name) (Date of Birth) (Last 4 digits of SS#)
meet my request for obtaining information & disclosures & uses by disclosing the following information (check boxes that apply) to:

1. Name (print): _____ Relationship: _____
 Appointment time Results of tests/x-rays Financial info Rx Info Treatment Info Medical History

2. Name (print): _____ Relationship: _____
 Appointment time Results of tests/x-rays Financial info Rx Info Treatment Info Medical History

3. Name (print): _____ Relationship: _____
 Appointment time Results of tests/x-rays Financial info Rx Info Treatment Info Medical History

* 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 medical providers and any government agency that may request your information.

To release information to your designee(s), the designee(s) must be able to verify the right to the information by supplying PFM with the last 4 digits of your (the patient's) Social Security Number.

I understand:

- the purpose of this authorization is to meet the patient's request for information disclosures & uses.
- that I have the right to refuse to sign this authorization & that my treatment will not be conditioned on signing.
- that this authorization is effective until revoked or terminated by the patient or the patient's personal representative by submitting a written revocation to the HIPAA Officer.
- that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.
- that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient & may no longer be protected by federal or state law.

Date: _____
Signature of patient or signature of personal representative (as defined by HIPAA) & documentation

Date: _____
Signature of receiving employee copy of HIPAA form given to patient
(HIPAA Authorization 8/18/10) 1 of 1