PALMETTO FAMILY MEDICINE

109 Barton Creek Court Columbia, SC 29229
803.256.2286 VOICE

Request for Records to be sent TO PFM

Authorization to Use & Disclose Protected Health Information

The information requested is to be disclosed to Palmetto Family Medicine of Columbia, PA for the continuation of primary care treatment.

Medical Records/Information requested for the following patient

I, ______________________________ (print patient's full name), request that all medical records regarding treatment be released for treatment dates from_______________ to _________________. Patient DATE OF BIRTH__________________

Medical Records/Information requested **FROM** the following physician/practice

*Physician's Full Name: ________________________________

*Address: ________________________________

*Phone: ____________________ *Fax: ____________________

* Must be complete in order for information to be sent

Medical Records/Information is to be disclosed **TO** the following:

Palmetto Family Medicine of Columbia

- ☐ J. Frank Martin, Jr., MD
- ☐ Sarah S. Cottingham, MD
- ☐ Bhadrik Patel, MS, PA-C

Fax: (803) 419-8248

- ☐ Russell E. Ditzler, MD
- ☐ Jayne W. Koehler, MS, PA-C

Fax: (803) 419-4733

I understand:

- 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.

OFFICE ONLY Records RECEIVED by employee (initials) _______________Date: _____________

PALMETTO FAMILY MEDICINE
109 Barton Creek Court Columbia, SC 29229
803.256.2286 VOICE 803.419.8430 FAX

Request for Records to be sent **FROM** PFM to a new provider

Authorization to Use & Disclose Protected Health Information

The information requested is to be disclosed BY Palmetto Family Medicine of Columbia, PA for the continuation of primary care treatment.

Medical Records/Information requested for the following patient

I, ______________________________ (print patient's full name), request that all medical records regarding treatment be released for treatment dates ________________ to ____________. Patient birth date ______________________

.Medical Records/Information requested **FROM** the following physician/practice

Palmetto Family Medicine of Columbia

J. Frank Martin, Jr., MD

Sarah S. Cottingham, MD

Bhadrik Patel, MS, PA-C

Fax: (803) 419-8248

Russell E. Ditzler, MD

Jayne W. Koehler, MS, PA-C

Fax: (803) 419-4733

Medical Records/Information is to be disclosed **TO** the following:

*Full Name: ____

*Address: ____

*Phone: ______________________________ *Fax: ______________________________

* Must be complete in order for information to be sent

I understand:

- 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 Request for Records FROM PFM given to patient

OFFICE ONLY Records sent by employee (initials) ______________ Date: ____________

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

PALMETTO FAMILY MEDICINE

109 Barton Creek Court Columbia, SC 29229 803.256.2286 Voice 803.419.8430 FAX

GENERAL INFORMATION REQUEST OF Authorization for Release of Patient Information for Handicap/Disability/Life Insurance/FMLA Application

I, ______________________________/____________ give permission to PFM to
(Patient Name, Print) & (Print Date of Birth)
disclose the following protected health information listed in the description section below.

Entity or Person to receive the information:

*Full Name (printed)____

*Address ____

*Fax Number ____

* Must be completed for information to be sent.

Description of information to be disclosed:____

____

____

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.
- that this practice has 15 days from the date of receiving this request to provide me with access to or a copy of my information.

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

Description of PERSONAL REPRESENTATIVE (attach documentation)______________________________

_______________________________________ Date: ____________________
Signature of receiving employee ☐ copy of GENERAL INFO REQUEST given to patient

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Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that I have been presented the Notice of Privacy Policies for the above office, detailing how my information may be used or disclosed as permitted under federal and state law. I understand the contents of the Notice.

Patient Name: printed ____________________________

Patient Birth date: ______________________________

Patient Signature: ____

I request the following restriction(s) concerning the use of my personal medical information. Please list.

OFFICE USE If Acknowledgement is not signed, mark reason EMPLOYEE initials __________

- ☐ *Patient refused to sign* ☐ *Mailed to patient but not returned to us.*
- ☐ *Emergency situation & no time to give notice or to receive a signature*
- ☐ *Presented to patient but communication failure prevented us from receiving the acknowledgement.*
- ☐ *Other (detail)____*

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Request for ACCESS RIGHTS

Date: ____/____/____

I, ______________________________/_______________/_______________ am requesting to inspect or get a copy
(Print Patient's Full Name) (Date of Birth) (last 4 digits of SS#)
of my protected health information.

I understand:

- that there is certain information to which I cannot have access.
- that this practice has 30 days from the date of this request to provide me with access to or a copy of my information.
- that I may be charged a reasonable cost based fee to obtain this information.
- that this practice may deny my request.

The information to which I want access is or includes ____________________________________

____

____.

PFM will contact you as to our decision and to get further information about delivery of your information. Please list how or where you wish to be contacted with our decision.

_______ List address and or phone number ____

☐ If access is denied, I wish to be contacted about receiving a summary of the information.

____

Signature of patient or personal representative (as defined by HIPAA).

Description of Personal Representative's Authority (attach necessary documentation)___________

____

OFFICE ONLY Receiving employee (initials) _______________Date: ______________
Employees will forward requests immediately to the PRIVACY OFFICER.