SC Internal Medicine Associates and Rehabilitation, LLC

Patient Authorization for Disclosure of Protected Health Information (PHI) to an Individual

This form allows you to indicate which individuals you authorize to have access to your protected health information, for reasons other than treatment, payment and healthcare operations (reasons already allowed by law). Please review it carefully.

Please print all information. Form must be signed and dated each year, see page 2.

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

I authorize the practice listed below to disclose or share my protected health information (PHI):

Practice Name: **SC Internal Medicine Associates and Rehabilitation, LLC**

Provider: _____

Address: **One Wellness Blvd., Suite 200**

City: **Irmo** State: **SC** Zip: **29063**

Phone: **803-749-1111** Fax: **803-749-0050**

I authorize the practice to disclose or provide protected health information about me to the individual(s) listed below (list each family member, friend, or other individual to receive PHI):

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request

☐ Other (please specify): _____

I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above (check only those items of your record to be disclosed):

- ☐ Entire patient record
- ☐ Office notes ☐ Lab results ☐ X-rays, image results
- ☐ Hospital, nursing home, home health, hospice, and other physician records
- ☐ Record of HIV and communicable disease testing
- ☐ Record of mental health or substance abuse treatment
- ☐ Financial history report (previous 3 years only)
- ☐ Only send the following: _____

This authorization will expire at the end of the calendar year (December 31) of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list date of expiration if earlier than end of calendar year): _____

As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. You may revoke an authorization at any time, in writing, except to the extent that your Healthcare Provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient Signature Date

You have the right to receive a copy of signed authorizations upon request.