

**THE INFORMATION PROVIDED IN THIS FORM WILL BE RELIED UPON BY ALL HEALTH CARE PROVIDERS OF GREENVILLE HEALTH SYSTEM UNLESS REVOKED OR MODIFIED BY THE PATIENT IN WRITING.**

**AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION**

Patient Full Name (PRINT) \_\_\_\_\_ MRN \_\_\_\_\_ DOB \_\_\_\_\_

Authorization for Disclosure of Medical Information: The privacy of your medical information is important. We will discuss your medical condition with person(s) you designate.

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (Check and complete one)**

The following family members or other individuals may receive information regarding my medical condition:  
*Print first and last name(s)* \_\_\_\_\_

**OR**

Any family member or other individual inquiring about my medical condition may receive information from my provider, EXCEPT the following individuals: *Print first and last name(s)* \_\_\_\_\_

**You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.**

**NOTE: This designation does not give the above named individuals the right to make health care decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.**

**Confidential Communication:** Please provide phone number(s) where we can reach you:

Home: \_\_\_\_\_  Work: \_\_\_\_\_  Cell phone: \_\_\_\_\_  Other \_\_\_\_\_

**Messages:** A request for return calls may be left on the following answering machine or voice mail: *(Check all that apply)*

Home  Work  Cell Phone  I do not authorize

I authorize my medical information to be left on the following answering machine or voice mail: *(Check all that apply)*

Home  Work  Cell Phone  I do not authorize

If we are unable to reach you or leave a message at the above phone number(s), please indicate with whom we may leave a message for you to call our facility.

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

*Note: An automated appointment reminder system may call the number listed in our data base.*

**Signature:** I hereby authorize the disclosure of my medical condition and information as described above.

Patient/Patient's Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

PRINT Name (if Patient's Representative): \_\_\_\_\_

Relationship to Patient (if Patient's Representative): \_\_\_\_\_

GHS Representative: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_