Authorization to Disclose Information

Internal Medicine Associates of Greenville, P.A.

I, ________________________________ authorize and permit Internal Medicine Associates of Greenville, P.A. to disclose the following medical information: (check all that apply)

- ❑ Services rendered at this office (including participation in research studies)
- ❑ Last office visit, laboratory and/or x-ray test results
- ❑ Information regarding mental illness, substance abuse, or infectious diseases
- ❑ Medications prescribed
- ❑ Scheduled appointments / telephone confirmation of appointments on answering machine
- ❑ Billing Statements / Correspondence from this office
- ❑ Email correspondence with PCC department
- ❑ Other (Please Specify)

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To the following family member or person listed below:

Name: _________________________ Relationship to Patient:______________Phone #_____________

Name: _________________________ Relationship to Patient:______________Phone #_____________

This authorization is effective ___________________ and shall continue to be effective until otherwise revoked in writing by me. If your wish to revoke this authorization, you must do so in writing to your physician at Internal Medicine Associates. If you choose to revoke this authorization, it will become effective upon receipt but will not apply to disclosures previously made with your consent.

My signature below acknowledges that a copy of the privacy practices followed at Internal Medicine Associates of Greenville is available to me upon request.

Patient Name: ________________________________ Date of Birth: _____________

Signature: ____________________________ Social Security # _________________

Or Power of Attorney: ____

For Office Use Only

Date Received: ____________ By: __________________________ Act. #_________