Lovelace Family Medicine

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

*This form allows **Lovelace Family Medicine** to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.*

Patient Name:_____

Date of Birth:_____ Main Contact Number :_____

Mailing Address:_____

_____

COMMUNICATING WITH YOU

Phone

☐ Main Contact Number Above

☐ Other :_____

Detailed Messages Permitted

☐ Text (SMS)* ☐ Voicemail / Answering Machine ☐ None

☐ Text (SMS)* ☐ Voicemail / Answering Machine ☐ None

Email

☐ _____

☐ All information from this practice

☐ Appointment information only (request / confirm / cancel)

☐ Data Breach Notifications

☐ Billing / Insurance Information

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may communicate to the family members, friends, or caregivers listed below.

Spouse / Partner: _____

Phone: _____

*Email: _____

Other: _____

Phone: _____

*Email: _____

Relationship: _____

Check the box next to each type of information this practice may share.

☐ All information ☐ Prescriptions ☐ Appointments (request / confirm / cancel) ☐ Billing / Insurance

☐ Other :_____

Do Not Include:

☐ Mental health records ☐ Communicable diseases (e.g., HIV / AIDS) ☐ Alcohol / drug abuse treatment

** I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk. This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.*

YOUR PHOTOS & MULTIMEDIA

☐ Photo received from you or personal representative

☐ Photo taken by staff (e.g., pre/post procedure)

☐ Other :_____

Photos/Images may be used/posted:

☐ In office

☐ On office's website

☐ Other :_____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.

Patient/Personal Representative Signature:_____ Date: _____

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney)
(Attach documentation to support the personal representative's authority if not already on file with the practice)

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been terminated :_____

The termination **must** be in writing and filed with the original authorization.
Date original signed authorization received:

☐ Copy of original authorization provided to patient/personal representative (check if yes)

Notes : _____

_____

_____

_____

Lovelace Family Medicine, PA

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  _____
- ☐ Other:_____

  _____

Prepared By _____

Signature _____

Date _____

Audio or Video Recording

In the interest of your privacy, as well as that of our workforce, unauthorized audio or video recording by patients, family members, and/or visitors is **strictly prohibited**. Personal devices with an audio and/or video recording function should not be used or be visible in the office and must be stored accordingly.

To the extent a member of our workforce is aware of any unauthorized attempt to photograph or record a patient and/or workforce member, the workforce member will take reasonable steps to ensure that patients and/or workforce members are not photographed within the office.

We respectfully request that you turn off or silence your cell phone during your office visit.

By signing below, you acknowledge you understand the above office policies and agree to abide by them.

_____

Printed Name

_____ _____

Signature Date

Lovelace Family Medicine

Previous balances will be paid before reacceptance. ACC patients must go through New Patient Process.

Name:_____ Date of Birth:_____
Address:_____ Phone:_____

New Patient Past Medical History Form

Have you been seen by a doctor anywhere in the last 5 years ☐Yes ☐No

Do you have a Medicare Advantage plan ☐Yes ☐No *(We only accept traditional Medicare)*

Reason for wanting to establish care? *(general wellness, problems, etc)*

_____

_____

Surgical History *(Type, body part, date)*:

_____

_____

Family History: (Alive, deceased, medical problems)

Father: _____

_____

Mother: _____

_____

Siblings: _____

_____

Other: _____

_____

Social History:

Relationship: ☐ Married ☐ Divorced ☐ Single

Living Situation:_____

Children: Yes No If yes, how many and age(s)?_____

Employment:_____

Medications: _____

_____

Allergies: _____

_____

Do you have any relatives that are patients of the practice? ☐Yes ☐No
If yes, whom and relationship: _____

Signature: _____ Date: _____

Lovelace Family Medicine

Los saldos anteriores se pagarán antes de la reaceptación. Los pacientes del ACC deben pasar por el proceso de nuevo paciente.

Nombre:_____ Fecha de Nacimiento:_____
Dirección:_____ Teléfon:_____

Formulario de Historial Médico Pasado de Paciente

¿Razón para querer establecer la atención? (bienestar general, problemas, etc.)

_____
_____
_____

Historial quirúrgico (tipo, parte del cuerpo, fecha):

_____
_____
_____

Historia familiar: *(vivo, fallecido, problemas médicos)*

Padre: _____
_____

Madre: _____
_____

Hermanos: _____
_____

Otros: _____
_____

Historia Social:

Relacion: ☐ Casado ☐ Divorciado ☐ Soltero ☐ Pareja
Situacion de Vida:_____
Hijos: ☐ Sí ☐ No Edades?
Empleo:_____

Medicamentos: _____
_____

Alergias: _____
_____

¿Tiene familiares que sean pacientes de la práctica? ☐ Sí ☐ No
En caso afirmativo, ¿con quién y que es la relación?: _____

Firma: _____ Fecha:_____

Lovelace Family Medicine, PA
Notice of Privacy Practices
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice, please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by:

-Posting the new Notice in our office
-If requested, making copies of the new Notice available in our office or by mail
-Posting the revised Notice on our website:
www.lovelacefamilymedicine.con

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment and, if you are unavailable, we may leave the information with another member of your household or on your voice mail. We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. Examples include: Marketing, and/or Disclosures for any purposes which require the sale of your information. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice

has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and obtain a copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. If requested, we will provide you a copy of your records in an electronic format. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting a request in writing or requesting a form from the Privacy Officer. Exception- your physician must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, as a result of an authorization signed by you or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically. You have a right to receive notification of any breach of your protected health information.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at (803)364-4852 for further information about the complaint process.

This notice is revised and published and becomes effective on August 28, 2013 superseding previous notice dated October 18, 2006.

Date _____ **Lovelace Family Medicine, P.A.** **Chart #** _____

PATIENT INFORMATION **Account #** _____

PATIENT NAME: _____ CELL PHONE # _____

HOME STREET ADDRESS:_____ HOME PH#: _____

CITY,STATE,ZIP_____ WORK PH#: _____

MAILING STREET OR BOX ADDRESS:_____ EmailADDRESS_____

CITY,STATE,ZIP_____ EMPLOYER: _____

DOB: _____ SEX: _____ ADDRESS: _____

SOCIAL SECURITY#: _____ _____

PREFERRED LANUAGE _____ RACE_____

CIRCLE PREFERENCE OF COMMUNICATION: ☐ PRINTED ☐ ELECTRONIC ☐ PHONE

SPOUSE'S NAME: _____ WORK PH#: _____

EMPLOYER: _____ ADDRESS: _____

NAME & PHONE NUMBER OF EMERGENCY CONTACT:

NAME: _____ RELATION TO PATIENT: _____

HOME PH#: _____ WORK PH#: _____ PAGER/CELL PH#: _____

IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT:

NAME OF RESPONSIBLE PARTY: _____

RELATIONSHIP TO THE PATIENT: _____ SOCIAL SECURITY#: _____

EMPLOYER: _____ WORK PH#: _____ EXT: _____

PRIMARY COVERAGE	**SECONDARY COVERAGE**
INSURANCE CO: _____	INSURANCE CO: _____
NAME OF INSURED: _____	NAME OF INSURED: _____
INSURED'S DATE OF BIRTH _____	INSURED'S DATE OF BIRTH_____
ID/POLICY#: _____	ID/POLICY#: _____
GROUP#: _____	GROUP#: _____
INSURED'S SS# _____	INSURED'S SS#_____ _____
INSURED'S EMPLOYER_____	

***Please give a copy of your insurance card to the front desk personnel**.

PATIENT/PARENT SIGNATURE_____ DATE _____

AUTHORIZATION FOR ASSIGNMENT OF MEDICAL BENEFITS AND RELEASE OF INFORMATION

1. I hereby authorize and direct Lovelace Family Medicine, P.A. to provide such services for me as they deem reasonable and necessary.
2. I hereby authorize my insurance benefits to be paid directly to Lovelace Family Medicine, P.A.
3. I hereby authorize the release of pertinent information necessary to process my claims and copy of this authorization to be used as an original.
4. I understand I am responsible for payment of any services not covered by my insurance company.
5. I understand that all payments, copays, and deductibles are due at the time of service.
6. I understand that if I fail to cancel four appointments in one year without notification ahead of time that I may be dismissed from the practice. If I fail to cancel two appointments, I may be charged $5.00 billed directly to me.
7. I understand there is a $15.00 charge for returned checks.
8. I understand Lovelace Family Medicine, P.A. files insurance and accepts assignment for Medicaid, Medicare, Blue Cross/Blue Shield, PPC, State Health Plan, Health Care Savings, Health Source and Carolina Care Plan on my behalf.

NOTICE CONCERNING COMPLAINTS:

Complaints about physicians as well as other licensees and registrants of the South Carolina State Board of Medical Examiners, including physician's assistants, may be reported for investigation at the following address:

Carolina Medical Review
250 Berryhill Road, Suite 101
Columbia, SC 29210

Assistance in filling a complaint is available by calling 1-800-583-2236

PATIENT NAME (PRINT): _____ DATE: _____

PATIENT/PARENT SIGNATURE: _____

LOVELACE FAMILY MEDICINE, PA

Authorization to Disclose Health Information

Patient Name: _____ PHONE#_____

Date of Birth: _____ Chart Number: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:
   Lovelace Family Medicine, PA 803-364-4852/FAX 803-364-2014
3. The type and amount of information to be used or disclosed is as follows:

- ☐ problem list
- ☐ medication list
- ☐ immunization record
- ☐ most recent history and physical
- ☐ most recent provider encounter
- ☐ procedure record
- ☐ laboratory results Dates: from _____ to _____
- ☐ x-ray and imaging reports Dates: from _____ to _____
- ☐ office notes Dates: from _____ to _____
- ☐ entire record
- ☐ Other: _____

_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

Name: _____

Address**:** _____

_____

Purpose of Release:

☐ Medical Care ☐ Legal representation

☐ Other: _____

6. I understand that I have a right to revoke this authorization at any time. I must revoke this authorization in writing to the privacy officer of this practice. If I revoke this authorization, I understand that the revocation will not apply to information that has already been released. Unless otherwise revoked, this authorization will expire in six months from the date of authorization.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment by my healthcare providers. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state privacy rules. If I have questions regarding the disclosure of my health information by this practice, I can contact the privacy officer.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient Signature of Witness

_____

Description of Representatives's Authority (attach any necessary documentation)

LOVELACE FAMILY MEDICINE, PA

Authorization **Request for** Disclose Health Information

Patient Name: _____ PHONE # _____

Date of Birth: _____ Chart Number: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

Name: _____

Address: _____

_____

3. The type and amount of information to be used or disclosed is as follows:

- ☐ problem list
- ☐ medication list
- ☐ immunization record
- ☐ most recent history and physical
- ☐ most recent provider encounter
- ☐ procedure record
- ☐ laboratory results Dates: from _____ to _____
- ☐ x-ray and imaging reports Dates: from _____ to _____
- ☐ office notes Dates: from _____ to _____
- ☐ entire record
- ☐ Other: _____

_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

Name: **Lovelace Family Medicine, PA** **803-364-4852/FAX 803-364-2014**

Address**: PO Box 630, 600 N. Wheeler Avenue**
Prosperity, SC 29127

Purpose of Release:

- ☐ Medical Care ☐ Legal representation
- ☐ Other: _____

6. I understand that I have a right to revoke this authorization at any time. I must revoke this authorization in writing to the privacy officer of this practice. If I revoke this authorization, I understand that the revocation will not apply to information that has already been released. Unless otherwise revoked, this authorization will expire in six months from the date of authorization.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment by my healthcare providers. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state privacy rules. If I have questions regarding the disclosure of my health information by this practice, I can contact the privacy officer.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient Signature of Witness

_____

Description of Representative's Authority (attach any necessary documentation)