GREENVILLE HEALTH SYSTEM

AUTHORIZATION FOR DISCLOSURE OF HOME HEALTH MEDICAL INFORMATION

Patient Full Name _____ 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:

Name _____ Phone # _____

Mailing Address _____

Name _____ Phone # _____

Mailing Address _____

Name _____ Phone # _____

Mailing Address _____

OR

☐ Any family member or other individual inquiring about my medical condition may receive information from my provider, EXCEPT the following individuals:

Name _____ Phone # _____

Mailing Address _____

Name _____ Phone # _____

Mailing Address _____

Name _____ Phone # _____

Mailing Address _____

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

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

Text Message Waiver:

With your permission, Greenville Health System (GHS) Home Health may use text messaging to remind you of upcoming appointments for your home health care. We will limit information sent via text message to the minimum necessary. Greenville Health System does not encourage text messaging but will allow it in this limited circumstance with your consent.

We want to make sure you know that text communications are NOT secure communications. Consequently, text messages sent by Greenville Health System to you are not encrypted (and therefore not considered secure) and the messages you send back to us are likewise neither encrypted nor secure.

We have just explained to you the security risks associated with communicating through text messages. If you choose to communicate with GHS Home Health, for home health care appointment reminders, we need your permission.

By providing your information below, you are granting permission to GHS Home Health to text upcoming home health care appointment times. It is your responsibility to notify GHS Home Health if your number changes.

Cell Phone: _____

Print name:

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'sRepresentative):_____

GHS Representative: _____Date: _____Time:____